DOCUMENT RESUME

ED 409 154 RC 021 107

AUTHOR	Marshall, Catherine A.; And Others
TITLE	An Examination of the Vocational Rehabilitation Needs of American Indians with Behavioral Health Diagnoses in New York State. Final Report.
INSTITUTION	Northern Arizona Univ., Flagstaff. American Indian Rehabilitation Research and Training Center.
SPONS AGENCY	National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
REPORT NO	ISBN-1-888557-70-2
PUB DATE	96
NOTE	129p.
CONTRACT	H133B30068
AVAILABLE FROM	American Indian Rehabilitation Research and Training Center, Northern Arizona University, Institute for Human Development, P.O. Box 5630, Flagstaff, AZ 86011 ($10).
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Action Research; *American Indians; *Delivery Systems; *Disabilities; Human Services; *Mental Disorders; *Public Agencies; Substance Abuse; *Vocational Rehabilitation
IDENTIFIERS	Barriers to Participation; *New York; Service Delivery Assessment

ABSTRACT

A participatory action research project examined vocational rehabilitation (VR) services provided in New York State to American Indians with behavioral health diagnoses, including dual diagnoses involving substance abuse. In 1991, the New York public VR system had 81 American Indians apply for VR services (only 2.8 percent of American Indians with disabilities that prevent them from working). Of the 81, 43 were accepted for services and 16 of these had a behavioral health diagnosis. Eight persons with such a diagnosis were closed as rehabilitated. A substantial number of American Indians who applied for VR services "refused services" at application or after eligibility was determined. Other data include a review of documentation on public agency cooperation and service delivery to disabled American Indians in New York; a summary of databases about this population, including those of the U.S. Census, Office of Mental Health, and office of Vocational and Educational Services for Individuals with Disabilities (VESID); and interviews with program clients, service providers on an Indian reservation, and VR agency staff. The project's "action" component was dissemination of research and training information at a statewide 2-day symposium in November 1995 in Syracuse, New York. Results indicate that while a comprehensive and integrated delivery system exists on paper, it fails to reach the service population studied. Recommendations focus on needs for aggressive outreach, cultural awareness, and greater program accountability. Contains 35 references. Appendices include data tables on disabled American Indians in New York and an annotated bibliography of literature available from VESID. (SV)

ED 409 154

AN EXAMINATION OF THE VOCATIONAL REHABILITATION NEEDS OF AMERICAN INDIANS WITH BEHAVIORAL HEALTH DIAGNOSES IN NEW YORK STATE

FINAL REPORT

1996

Principal Investigator: Catherine A. Marshall, Ph.D., CRC
Co-Investigators: Susanne Bruyère, Ph.D., CRC
David Shern, Ph.D.
Lois Jircitano, J.D.

American Indian Rehabilitation Research and Training Center

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

NORTHERN ARIZONA UNIVERSITY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Priscilla
Sanderson
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Institute for Human Development
Arizona University Affiliated Program
Northern Arizona University
PO Box 5630
Flagstaff, Arizona 86011-5630

Funded by the National Institute on Disability and Rehabilitation Research (NIDRR)
Office of Special Education and Rehabilitative Services, U.S. Department of Education, Washington DC
Grant No H133B30068

The content of this report is the responsibility of the American Indian Rehabilitation Research and Training Center and no official endorsement by the U.S. Department of Education should be inferred.

Northern Arizona University is an Equal Opportunity / Affirmative Action Institution

BEST COPY AVAILABLE

AN EXAMINATION OF THE VOCATIONAL REHABILITATION NEEDS OF AMERICAN INDIANS WITH BEHAVIORAL HEALTH DIAGNOSES IN NEW YORK STATE

FINAL REPORT

1996

Principal Investigator: Catherine A. Marshall, Ph.D., CRC
Co-Investigators: Susanne Bruyère, Ph.D., CRC
David Shern, Ph.D.
Lois Jircitano, J.D.

American Indian Rehabilitation Research and Training Center
Institute for Human Development
Northern Arizona University
PO Box 5630
Flagstaff, AZ 86011
(520) 523-4791

ISBN # 1-888557-70-2

TABLE OF CONTENTS

List of Tables iv
List of Figures v
Acknowledgments vii
Summary ix
INTRODUCTION 1
SUMMARY OF RELEVANT LITERATURE 3
METHODOLOGY 5
  Subject Population/Participants 7
RESULTS 8
  Existing Documentation 8
  Summary of Existing Databases 26
    U.S. Census Data 26
    Office of Mental Health Data 27
    Vocational and Educational Services for Individuals with Disabilities Data 31
      American Indian applicants 31
      American Indian applicants accepted for services 35
      American Indian behavioral health applicants 42
  Qualitative Data 48
    Behavioral Health 48
    American Indian Community 51
    Public Vocational Rehabilitation 53
  DISCUSSION AND PROJECT OUTCOMES 53
    American Indians with Behavioral Health Diagnoses 55
    Considerations Regarding Level of VESID Service Delivery 56

Cultural Considerations 58
"Lessons-Learned" Regarding Participatory Action Research Strategies 60
Project Action Outcomes 61
CONCLUSIONS AND RECOMMENDATIONS 66
Recommendations 69
References 73
Appendix A: PAC Letters 78
Appendix B: Disability Status of American Indian Civilian Non-institutionalized Persons in Non-reservation Land Areas of New York State in 1990 84
Appendix C: Frequencies of Persons Ages 15 to 64 Living on Reservation and Trust Land in New York State in 1990, by Reservation 87
Appendix D: Disability Status of American Indian Civilian Non-institutionalized Persons on American Indian Reservations and Trust Land in New York State in 1990 89
Appendix E: Rehabilitation of American Indians with Behavioral Health Disorders in New York State: Workshop Agenda 92
Appendix F: Literature from the Office of Vocational and Educational Services for Individuals with Disabilities 96

LIST OF TABLES

Table 1 Occupations at Closure of Rehabilitated VESID American Indian Behavioral Health Consumers in 1991 48

LIST OF FIGURES

Figure 1 Disabilities of OMH American Indian Working-Age Clients During 1991 Survey Week 29

Figure 2a Diagnosis Categories of OMH American Indian Working-Age Clients During 1991 Survey Week 30

Figure 2b SPMI/SED Status of OMH American Indian Working-Age Clients During 1991 Survey Week 30

Figure 3 Frequencies of Services Provided to VESID American Indian Applicants in 1991 32

Figure 4 Type of Closure of VESID American Indian Applicants in 1991..... 33

Figure 4a Reasons Given for VESID American Indian Applicants *Not Accepted* for Services in 1991 34

Figure 4b Reasons for Closure of VESID American Indian Applicants Accepted for Services but *Not* Rehabilitated 35

Figure 5 Referral Sources of VESID American Indian Applicants Accepted for Services in 1991 36

Figure 6 Frequencies of Services to VESID American Indian Consumers in 1991 37

Figure 7 Primary Source of Support at Application of VESID American Indian Applicants Accepted for Services 39

Figure 8a Major Disabling Conditions of VESID American Indian Consumers in 1991 40

Figure 8b Major Disabling Conditions of VESID American Indian Applicants *Not Accepted* for Services in 1991 41

Figure 9 Major Disabling Conditions of VESID American Indian Consumers Successfully Rehabilitated in 1991 42

Figure 10 Occupations at Closure of VESID American Indian Successfully Rehabilitated Consumers in 1991 43
Figure 11 Behavioral Health Diagnoses of VESID American Indian Applicants Accepted for Services in 1991 43
Figure 12 Behavioral Health Diagnoses of VESID American Indian Applicants *Not Accepted* for Services 44
Figure 13 Frequencies of Services Provided to VESID American Indian Behavioral Health Consumers in 1991 45
Figure 14a Frequencies of Services Provided to Rehabilitated VESID American Indian Behavioral Health Consumers 46
Figure 14b Frequencies of Services Provided to VESID American Indian Behavioral Health Clients that were *Not* Rehabilitated...... 47

ACKNOWLEDGMENTS

By definition, participatory action research involves the participation of members of a given community. Relationships form. Trust develops. This project attempted to utilize participatory strategies on a state-wide basis and found that a sense of "community" is much harder to instill in a research effort at the state level than at a true community level. Nonetheless, several individuals throughout New York State believed in the importance of investigating the level of service delivery available to American Indians with behavioral health diagnoses--they are among those listed below in the Project Advisory Committee (PAC); their belief in the importance of this project was always sincerely appreciated by the research team. It is hoped that information provided in this report will enable interested PAC members to continue the work in their local communities. The researchers would also like to acknowledge two individuals from the AIRRTC who worked tirelessly to assist in data analysis, Patricia M. Rose, M.S., CRC and George Gotto, IV, M.A.

Project Advisory Committee

Barbara T. Abrams, Director
American Indian Program
Cornell University
Ithaca, New York

Frank Abrams
Albany, New York

William Anthony, Ph.D.,
Project Director
RTC for Persons with Long-Term Mental Illness, Center for Psychiatric Rehabilitation
Boston University
Boston, Massachusetts

Jim Bronstein, Program Coordinator
Opportunities Unlimited of Niagara
Niagara Falls, New York

Project Advisory Committee, continued

David Burganowski, Associate Director
RRCEP II
State University of New York at Buffalo
Buffalo, New York

William Carpenter, Manager
Educational Institution Linkages
Office of Vocational & Educational Services for Individuals with Disabilities (VESID)
Albany, New York

Ken Dougherty
Lewiston, New York

Joanne Francis
Hogansburg, New York

Dr. Frank Herstek
BOCES
Sanborn, New York

Anthony Hunter, Director
Health and Human Services
American Indian Community House
New York, New York

Ron LaFrance
Ithaca, New York

Elissa Lang, M.Ed., M.A., CRC,
Director of Psychiatric Rehabilitation
New York Hospital-Cornell Medical Center
White Plains, New York

Grace Sage, Ph.D.
Cornell University
Psychological Services
Gannett Health Center
Ithaca, New York

Dr. Ed Starr
State University of New York at Buffalo
Buffalo, New York

Margaret Terrance, Executive Director
St. Regis Mohawk Tribe Health Services
Hogansburg, New York

Minerva White, Coordinator
Native American Indian Education Unit
New York State Education Department
Albany, New York

Dan Wong, Ph.D., Assistant Professor
Dept. of Counseling, Research, Special Education & Rehabilitation
Hofstra University
Hemstead, New York

SUMMARY

This research was conducted through the American Indian Rehabilitation Research and Training Center (AIRRTC) located at Northern Arizona University and in collaboration with The Program on Employment and Disability in the School of Industrial and Labor Relations at Cornell University. The mission of the AIRRTC is to conduct research and training on a nationwide basis that will contribute to an improvement in the quality of life of American Indians with disabilities. The Program on Employment and Disability at Cornell focuses on workplace issues for persons with disabilities and provides training and technical assistance to employers, supervisors, labor union representatives, schools, rehabilitation facilities, advocacy groups, and persons with disabilities and their families. The primary purpose of the research was to examine the level of vocational rehabilitation (VR) and mental health services being provided in New York State to American Indians with behavioral health diagnoses, including those with dual diagnoses involving substance abuse.

Rehabilitation research has not addressed the extent to which American Indians with severe and persistent mental illnesses have successfully accessed the public VR system. Nor does the literature address what difficulties Indian people with a dual diagnosis face when seeking rehabilitation services. This project proposed to examine these issues in New York State, and to work with both the public VR agency and the public mental health agency in order to ensure appropriate service delivery to American Indians with disabilities.

The project followed a participatory action research model--a type of applied social research strategy that contrasts with the "professional expert

model" (Whyte, 1989). Participatory action research is a research strategy where members of the target group to be studied are used as collaborators in the research design, implementation, and follow-up. Another distinctive emphasis in participatory action research is on useful outcome or action objectives. One test of the scientific value of an set of research findings, according to Whyte "should be what can be done with them toward solving practical problems" (1989, pg. 369). This project endeavored to provide an "action" component with the dissemination of research and training information at a statewide, two-day training symposium held on November 9-10, 1995 in Syracuse, New York. Hosted by Cornell University, School of Industrial and Labor Relations, and conducted in collaboration with the AIRRTC, the symposium provided a forum for the presentation and discussion of an earlier version of this *Final Report,* entitled *Interim Working Paper* (did not include qualitative data, discussion, conclusions, and recommendations). The symposium afforded participants an opportunity for discussion regarding next steps in making statewide systems change to enhance vocational rehabilitation services for American Indians in New York State with behavioral health disorders.

Unfortunately, there may be a great deal of work to be done as regards statewide systems change. While some symposium participants felt that considerable change has taken place to improve the access American Indians with behavioral health diagnoses have to the public VR system, no data were provided to support this belief. In terms of the results, the number of Indian people with behavior health diagnoses represented in the service populations reviewed in this research leads to serious questioning of the level of services being provided. The United States 1990 census reported there to be 5,447

American Indians with disabilities in New York State; of these, 2,881 (53%) persons with disabilities were prevented from working.

The Rehabilitation Services Administration provided 1991 data (the most recent data base available when this study was begun in 1994) which revealed that the public VR system in New York State had 81 American Indian persons apply for VR services, which constituted 2.8% of the total American Indian persons with disabilities that prevent them from working. Of these 81 persons, 23 were rehabilitated. Thus, **approximately .8% (less than 1%) of all the American Indian persons in New York State with disabilities which prevented them from working were rehabilitated in 1991**.

Of the 81 American Indians who applied for VR services in 1991, 43 (51%) were accepted for services. Of these 43 individuals, 16 (37%) had a behavioral health diagnosis. Of the 16 individuals with a behavioral health diagnosis, 8 were closed as rehabilitated. A substantial number of number of American Indians who applied for VR services "refused services" either at application or after eligibility was determined. Clearly, more research is needed to understand why more American Indians with disabilities do not approach the VR system, and when they do, they refuse services.

Recommendations from this research effort include the need to ensure VR agency responsiveness to the diverse needs of Native people, aggressive outreach within American Indian communities, reduction of barriers to timely access of public VR data regarding service delivery, a comprehensive study of the meaning(s) of "refused services," demonstrated VR intervention to American Indians in proportion to their numbers in the population, demonstrated cultural-competency among VR administrators and counselors, opportunities for electronic networking among VR counselors working with American Indians, and community-focused research.

AN EXAMINATION OF THE VOCATIONAL REHABILITATION NEEDS OF AMERICAN INDIANS WITH BEHAVIORAL HEALTH DIAGNOSES IN NEW YORK STATE

Rehabilitation research has not addressed the extent to which American Indians with severe and persistent mental illnesses have successfully accessed the public vocational rehabilitation (VR) system. Nor has the rehabilitation literature addressed what difficulties Indian people with dual diagnoses face when seeking rehabilitation services. Researchers who analyzed rehabilitation acceptance and outcome rates for 10% of all national case closures during the period 1977-1984 concluded that "the mix of services currently available in the state-federal VR system and collaborating local, state and federal agencies, may not have kept pace with the changing needs and characteristics of the population of individuals who are seriously mentally ill. Additional research would be necessary to establish whether the gap between needs and available services has in fact increased over time . . . ." (Andrews, Barker, Pittman, Mars, Struening, & LaRocca, 1992, p. 13). Problems are compounded when the person with a severe and persistent mental illness also has a substance abuse disorder. According to Slaby (1991), "dual diagnosis, simply defined, refers to the concurrence of two separate diagnostic entities in one person. . . . such as [when] alcoholism occurs together with a psychiatric disorder such as major depression" (p. 3).

According to Polcin (1992), "the literature in the mental health and substance abuse fields suggests that a growing number of consumers seem to fulfill the criteria . . . for diagnosis in both mental health and substance abuse categories. . . . These 'dual diagnosis' consumers have presented special problems of assessment and treatment" (p. 30). Polcin suggested that "it may be that the treatment of dual diagnosis consumers in community programs is difficult because of the myriad ways that different treatment personnel and services may be used and coordinated. It seems that a prudent first step might be to gather descriptive data on how dual diagnosis consumers in community programs are conceptually viewed by clinicians as well as what kinds of treatments and services they receive" (p. 34).

As regards the mental health needs of American Indians, LaFromboise (1988) stated that American Indians "experience high rates of mental health disorders associated with social stress" (p. 388), and that "the extent to which Indians use private or public mental health services is unknown" (p. 391). The New York Office of Mental Health (OMH) agreed that more information regarding the service delivery needs of American Indians was needed. Dr. David Shern, Director, Evaluation and Services Research at OMH (at the time of the research) was a member of the research team.

According to Mr. William Carpenter, Manager, Educational Institution Linkages, Office of Vocational & Educational Services for Individuals with Disabilities (VESID), more information was needed in New York concerning the VR needs of American Indians with behavioral health diagnoses. He specified that this information would be particularly useful in regard to Indian people living in off-reservation areas (personal communication, January, 19, 1993). [The largest off-reservation population of American Indians in New York is located in New York City, and consists of approximately 27,531 persons (U.S. Department of Commerce and Bureau of the Census, 1992; 1993).]

SUMMARY OF RELEVANT LITERATURE

Research has indicated that "when considering national data from all VR agencies, the second largest broad disability category is mental illness, at 17.8 percent of all cases. . . . When the entire series is considered [RSA Code 500, psychosis, alcoholism, drug abuse, mental retardation, and autism], the number of people in VR agency caseloads across the country amounts to nearly 40 percent" (Garske, 1992, p. 23). From the perspective of the International Association of Psychosocial Rehabilitation Services (IAPSRS) (International, 1986), "people with mental illnesses are one of the largest groups of disabled people served under the VR system, but at the same time in many states it is nearly impossible to obtain services for individuals with a *severe* mental illness" (p. 2). The literature does not address issues related to accessing the public VR service delivery system as regards to American Indians with severe and persistent mental illnesses, and as stated earlier, nor is this information known as regards to the public mental health system. Further, we do not know to what extent difficulties may be compounded for American Indians when they experience a dual diagnosis.

However, there is no doubt but that any difficulties in obtaining services will be increased when the person with a severe mental illness also has a substance abuse disorder (see, e.g. Polcin, 1992; Slaby, 1991). Siris and Docherty (1990) stated that "patients carrying this co-morbidity frequently have no place to turn . . . people are suffering . . . ." (p. 339).

Miller and Wittstock (1981) highlighted the importance of culturally sensitive treatment techniques. For example, the authors recommended that "the use of the 'hot seat' or confrontation therapy needs to be carefully considered as a technique with Indian consumers. . . When used by white counselors with Indian consumers, the confrontation involved . . . may be perceived by the client as symbolic of the conflict between white and Indian cultures" (p. 15). The authors concluded that, "as effective as this technique may be with some populations, to many Indians it is degrading and destructive of self-esteem" (p. 15). According to O'Brien, Vanek, and Welper (1991), "the recent initiatives in mental health and substance abuse programming in the urban Indian health programs should continue to be supported and developed, since many of the leading causes of death are related either to mental health, such as suicide and homicide, or to substance abuse, such as cirrhosis, liver disease, and accidents" (p. 39).

Undoubtedly, issues related to the behavioral health of American Indians warrant attention by those who provide VR services. There exists a wealth of literature calling for more collaboration between state departments of mental health and VR in order to better provide for the rehabilitation needs of persons with severe and persistent mental illnesses (see, e.g. Brown & Basel, 1988; Katz, 1991). Specifically, in New York State, steps had been taken prior to the AIRRTC research effort to improve integrated service delivery between these two systems for consumers with mental illness. Steps had also been taken through VESID and the American Indian Coalition of Rehabilitation and Independent Living Service Programs to document the needs and preferred systems of service delivery as regards American Indians with disabilities residing within the Indian nation communities. However, as stated earlier, research documenting the rehabilitation needs of American Indians in off-reservation settings in New York State had not been conducted, and appeared to be particularly needed as regarded Indian people with behavioral health diagnoses.

Thus the purpose of this research was to: (1) examine the current level of vocational rehabilitation and mental health services being provided in

New York State to American Indians with behavioral health diagnoses, (2) assess whether or not additional services are needed to ensure successful vocational rehabilitation outcomes, and (3) identify opportunities to establish and/or strengthen collaborative programs between Vocational and Educational Services for Individuals with Disabilities (VESID) and the New York State Office of Mental Health (OMH). The specific research questions researchers attempted to address included:

1. What are the demographic characteristics of American Indians with behavioral health diagnoses found eligible for vocational rehabilitation services versus those found ineligible for services?
2. What patterns of service delivery exist for this population, if any, in the (a) delivery of vocational rehabilitation services through VESID, and (b) delivery of services through OMH?
3. To what extent does a comprehensive and integrated service delivery system exist to meet the needs of American Indians with behavioral health diagnoses in New York State?
4. What barriers can be identified that may prevent a comprehensive and integrated service delivery system from being fully implemented?

METHODOLOGY

According to Bruyère (1993), participatory action research (PAR) places a "special emphasis on useful outcomes" (p. 63). To this end, the researchers (including members of the affected community) worked to develop a project advisory committee (PAC) which would include representatives of the public and tribal agencies involved in the research, as well as American Indians with disabilities and interested community members (see, example letters; newsletter, Appendix A). Not only would the PAC assist the researchers in carrying out research that should result in useful outcomes to the community, but would also assist the researcher in formative evaluation processes to ensure that all steps of the research project were both relevant to the community and culturally appropriate.

After the development of a project advisory committee (PAC), the first steps in the research process were to review (a) all **existing documentation** regarding the needs of American Indians with disabilities in New York State, as well as (b) all **existing state VESID and OMH databases** regarding this population. Analyses of existing databases included 1991 VESID data provided by the Rehabilitation Services Administration in Washington (RSA), D.C.; 1991 data from OMH; and data from the 1990 United States census. VESID data provided by the federal Rehabilitation Services Administration were analyzed by AIRRTC staff using the Statistical Package for the Social Sciences (SPSSX), 10th Edition. OMH and the U.S. Census data were analyzed by the respective agencies.

It was anticipated that the project would further evolve as (a) case reviews of VESID consumers who are American Indian and who have a behavioral health diagnosis, and (b) case reviews of OMH consumers who are American Indian and who have a diagnosis which constitutes a severe and persistent mental illness, or who carry a dual diagnosis. It was anticipated that these statewide reviews, coupled with **qualitative data** obtained through interviews with key informants, would enable the researchers and the PAC to determine whether or not a more intensive needs assessment, for example, in a specific urban community, was warranted. Due to difficulties and delays in obtaining VESID data through New York State (the data were ultimately obtained, as mentioned earlier, through RSA), attempts were not made to conduct case reviews. However, though not as extensive as desired, qualitative data were obtained through interviews with key informants, including consumers, VESID staff, OMH staff, and tribal representatives.

Subject Population/Participants

Specifically, it was proposed that the population of interest would be those American Indians with behavioral health diagnoses, including those with dual diagnoses, who lived in **off-reservation** settings in New York State. However, in further consultation with one of the co-investigators experienced in working with American Indians in New York State, and with members of the PAC, it was determined that a more comprehensive approach was warranted, that is, considering the needs of American Indians with behavioral health diagnoses, including those with dual diagnoses, who lived in **off-reservation** settings, as well as **on-reservation populations**. Within the OMH system, the targeted population were those persons served through the Community Support Program, the purpose of which is "to help consumers diagnosed with severe and persistent mental illnesses live as independently as possible in the community . . . . The programs are built around the needs and preferences of consumers and designed to help consumers live in settings of their own choice, work to their full potential, and develop and maintain rewarding social relationships" (*Statewide comprehensive plan*, 1992). Within the VESID system, the population of interest were those persons diagnosed within the RSA Code 500 series. It is important to note that the design of this project called for data to be reviewed which applied only to American Indians in order to establish a baseline of service delivery to this population; no comparisons to the service delivery patterns of other ethnic minority populations were planned.

RESULTS

The results of this project will be presented in the following order: (a) a review of the existing documentation regarding the needs of American Indians with disabilities in New York State, (b) a summary of the 1991 VESID and OMH databases regarding this population, and (c) a summary of the qualitative data obtained through interviews with key informants.

Existing Documentation

The following documents made available through VESID were reviewed: *VESID Comprehensive Action Plan for Reform* (undated); *ACCESS: Plan for Ensuring Access for Individuals with Disabilities to All New York State Education Department Programs and Services* (1991); *Report to the Governor and Board of Regents of the Interagency Council for Vocational Rehabilitation and Related Services* (April 1993); *Opportunity & Independence: Meeting the Needs of New Yorkers with Disabilities* (July 1993); *Strategic Plan for Developing and Expanding Vocational Rehabilitation Services in New York State for Federal Fiscal Years 1994, 1995, and 1996; VESID 1990 Annual Report; VESID 1991 Annual Report; VESID 1993 Annual Report; New York State Plan for Education of Students with Disabilities 1993-1995; Integrated Employment: Implementation Plan Chapter 515, the Laws of 1992; 1992 Annual Update to State Plan for Independent Living Services for Federal Fiscal Years 1991, 1992 and 1993; Annual Report on Access* (1992); *1993 Amendment to the State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993 and 1994; Interim 1994 State Plan for the State Vocational Rehabilitation Services Program and the State Plan Supplement for the State Supported Employment Services Program; The New York State Plan for Vocational Rehabilitation and Supported*

Employment for Federal Fiscal years 1992, 1993 and 1994; American Indian Coalition of Rehabilitation and Independent Living Service Programs of New York State (undated); *American Indian Rehabilitation Presentation Outline* (undated); *Interim 1994 Title VII State Plan for Independent Living; Memorandum of Interagency Understanding Regarding Supported Employment* (1992); *Memorandum of Understanding Between the State Education Department Office of Vocational and Educational Services for Individuals with Disabilities and the Office of Mental Health* (1993); *Memorandum of Agreement Between the New York State Office of Mental Health and the State Education Department Regarding Cooperative Efforts to Improve Access and Delivery of Services to Persons Diagnosed with a Mental Illness and their Families* (1992); *Memorandum in Support of "An Act to Amend the Education Law, in Relation to Establishing Programs Providing Training and Technical Assistance for Employers of Individuals with Disabilities and Making an Appropriation Therefor"* (1993); *Memorandum on Managing VESID's Resources from Lawrence C. Gloeckler to All VESID Managers* (1993).

In an effort to ensure that VR and related services in the state of New York were provided in a coordinated and non-duplicative manner, the State Interagency Council for Vocational Rehabilitation and Related Services (State Interagency Council) was formed in 1989. The State Interagency Council included representatives from the Office of Advocate for the Disabled, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Department of Labor, Division of Veterans' Affairs, Commission for the Blind and Visually Handicapped within the Department of Social Services, Commission on Quality of Care for the Mentally Disabled, and the Education Department's Office of Vocational and Educational Services for

Individuals with Disabilities (The State Education Department & The University of the State of New York, Attachment 3.2A, p. 4 of 7, 1994). "The focus of interagency activities is to ensure that services provided by the State Education Department (SED) for persons with disabilities of any age are coordinated with services provided by other New York State agencies" (The University of the State of New York & The State Education Department Office of Vocational and Educational Services for Individuals with Disabilities, 1992).

Following the formation of the State Interagency Council, in 1992, legislation was passed that supported the belief that individuals with disabilities should have as many viable employment opportunities as possible and have the right to work at jobs in their communities on an equal basis with their non-disabled neighbors. This legislation was written in the *Laws of New York State, Chapter 515, the Laws of 1992*. The legislative intent of *Chapter 515* was that:

> "...new and evolving program initiatives designed to expand employment opportunities in integrated settings for persons with severe disabilities need to be recognized, encouraged, and fully coordinated with the existing service delivery system. As these initiatives evolve, and as the number of persons with severe disabilities who obtain employment in integrated settings increases, it will become imperative to have in place a coordinated, flexible service delivery system capable of meeting the needs of and expanding the options for persons with severe disabilities throughout the state" (*Report to the Governor*, April 1993, p. 11).

The responsibility of stimulating the development of a coordinated service delivery system, as specified in Chapter 515, was given to the State

Education Department's Office of Vocational and Educational Services for Individuals with Disabilities (VESID). In an effort to carry out this legislation the commissioners from New York's supported employment programs, which Include VESID, New York State Department of Social Services Commission for the Blind and Visually Handicapped (CBVH), New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), and New York State Office of Mental Health (OMH) signed a *Memorandum of Interagency Understanding Regarding Supported Employment* (The State Education Department & The University of the State of New York, Attachment 1.10A: page 5 of 16, 1994). The purpose of this memorandum of understanding was to pursue a cooperative processes whereby services to New York State citizens with severe disabilities were assured. In order to assure services to New York State citizens with severe disabilities the four supported employment programs agreed to:

A) Continue to develop, enhance and expand supported employment for persons with severe disabilities.

B) Establish a process that will improve the statewide management of supported employment programs by avoiding duplication of effort and funding, while assuring accountability.

C) Maximize the quality of service delivery ensuring a comprehensive, continuous, efficient and effective referral process, individual program planning, coordination of intensive vocational services with extended services, information collection and dissemination, and technical assistance.

D) Identify issues, policies and practices that present systemic barriers to effective participation of individuals with severe disabilities and develop appropriate resolutions to remove such barriers.

E) Establish a planning process, consistent with the directions of the State Interagency Council of Vocational Rehabilitation and Related Services for budget coordination, which defines and projects the numbers of people in need of intensive and extended services for each fiscal year and facilitates program and fiscal planning.

In order to accomplish these objectives, the parties to the *Memorandum of Understanding* agreed upon components of supported employment within the primary areas of: interagency planning and coordination, eligibility, service delivery to consumers, program development and coordination, and fiscal responsibilities.

In the *Memorandum of Interagency Understanding Regarding Supported Employment,* VESID and OMH entered into a direct collaboration regarding fiscal responsibilities. VESID agreed to provide "intensive service dollars to those supported employment programs, serving persons with mental illness who have access to extended care services through other sources" (The State Education Department & The University of the State of New York, Attachment 1.10A: page 10 of 16, 1994). OMH, in turn, agreed to provide funding for both intensive and extended case services through special employment programs at 100% of their net operating costs. VESID and OMH also initiated systems integration pilot programs in hopes of improving upon these mechanisms for funding supported employment services for persons with mental illness. In the *Interim 1994 State Plan for the State Vocational Rehabilitation Services Program and the State Plan Supplement for the State Supported Employment Services Program,* the State Education Department (SED) and The University of the State of New York agreed that "With input from consumers, providers and families, these programs will define more precisely how the financial and service resources of each agency will be blended to better support existing programs and to develop new supported employment opportunities" (Attachment 1.10A: p. 10 of 16, 1994).

In addition to the relationship that was initiated between VESID and OMH through the formation of the State Interagency Council and Chapter 515, these two state offices were also directed by Governor Cuomo in 1990 and 1991 to implement a plan that would integrate OMH programs with VESID's services (The University of the State of New York & The State Education Department Office of Vocational and Educational Services for Individuals with Disabilities, 1992). "The first step in implementing the plan to integrate services was to establish a Systems Integration Project site in each of OMH's five regions" (The New York State Education Department Office of Vocational and Educational Services for individuals with Disabilities, 1993, Attachment 9.4A, p. 10). The five regional sites that were chosen were in Western New York, Lake Shore Community Mental health Center in Buffalo; Central New York, St. Joseph's Health Center in Syracuse; Hudson River, Guidance Center in Westchester County; Long Island, Club House in Suffolk County and the North Shore University Hospital in Nassau County; and New York City, in Brooklyn and Manhattan. OMH was to contribute services drawn from its programs such as intensive case management, intensive psychiatric rehabilitation treatment, supported housing and special employment to the Systems Integration Project. VESID, in turn, was to contribute services from its technical assistance and support, including cross-systems training of all key participants at each of the five sites.

The minimum range of services to be provided by the initial Systems Integration Projects consisted of the following elements of services:

1) Assured access to OMH 24-hour psychiatric emergency services, inpatient hospitalization and outpatient clinical services;

2) Assured access to, or a direct provision of, OMH case management services to assist in obtaining and maintaining ongoing community support services, including housing, health care, socialization services and ongoing personal counseling and support;

3) Direct provision of OMH intensive psychiatric rehabilitation treatment services to assist individuals develop the skills and supports needed to choose and obtain the living, learning, work and socialization settings of their choice in the communities of their choice; and

4) Direct provision of VESID educational and vocational rehabilitation services to assist individuals develop the skills and supports needed to obtain and retain the academic and integrated employment options of their choice (The New York State Education Department Office of Vocational and Educational Services for individuals with Disabilities, 1993, Attachment 9.4A, p. 10).

The OMH and VESID systems integration plans were formalized through seven memoranda of understanding, two of which were made available to the investigators of this project. In November, 1992 Thomas Sobol, Commissioner New York State Education Department and Richard Surles, Commissioner New York State Office of Mental Health signed the *Memorandum of Agreement Regarding Cooperative Efforts to Improve Access and Delivery of Services to Individuals Diagnosed with a Mental Illness and their Families*. Through this *Memorandum of Agreement* the two State agencies formalized their commitment to develop complementary systems of education, vocational rehabilitation, independent living and mental health services. In accordance with Chapter 515 and Governor

Cuomo's mandate, this *Memorandum of Agreement* was expected to "enhance the ability of individuals diagnosed with mental illness, including children with serious emotional disturbances, to take their rightful places as participating members of their communities" (Sobol & Surles, 1992, p. 1). To achieve this goal, agencies agreed on the following strategies:

A) Clearly defining programmatic responsibility that each system will undertake in providing services for individuals diagnosed with mental illness, including children with serious emotional disturbances.

B) Developing State agency and local mechanisms for identifying and implementing new and modified administrative, programmatic and fiscal methods for meeting the mental health, educational and vocational rehabilitation needs of individuals diagnosed with mental illness, including children with serious emotional disturbances.

C) Enhancing the capacity of State and local programs to be more consumer and family focused, allowing for more involvement and choice for the individual and family.

D) Increasing the flexibility of existing funding streams in order to maximize the impact of the fiscal resources of both agencies (Sobol & Surles, 1992, p. 1).

The intention of this *Memorandum of Agreement* was to reinforce existing collaborative activities, form the basis for additional joint initiatives, and guide the activities of the State and local agencies committed to improving services for individuals diagnosed with mental illness. The authors of the memorandum wrote, "Through increasing community awareness of the potential of individuals diagnosed with mental illness, including children with serious emotional disturbances, and providing an increased and complementary range of services, consumers will be prepared for and supported in their recovery from mental illness, and in their integration or reintegration into education programs, meaningful employment and community roles" (Sobol & Surles, 1992, p. 1).

Another memorandum of understanding between SED and OMH signed by Lawrence C. Gloeckler, Deputy Commissioner of VESID, Richard C. Surles, Commissioner of OMH, and Thomas E. Sheldon, Executive Deputy Commissioner of SED (1993) described interagency systems considerations which included, among other items, characteristics of consumers and the process for referral. The consumer characteristics that were outlined in this *Memorandum of Understanding* and that were to be present when making a referral to VESID were:

A) The individual has a current diagnosis of mental illness which presents a substantial impediment to employment and requires vocational rehabilitation services to prepare for, enter, engage in, or retain gainful employment.

B) The individual perceives a need for a change in his/her current vocational role or status. This need could be prompted by the consumer's personal desire to make a role or environment change or by factors external to the consumer which are causing a need for change, e.g., a need to transition out of a day program.

C) The individual is committed to making a change in his/her current role and/or environment as indicated by consumer declarations that change is desired and seen as positive and possible.

D) The individual's communications and interactive behaviors indicate a readiness and willingness to participate in a rehabilitation counseling relationship, e.g., a willingness to discuss and declare vocational aspirations and to attend and respond to the coaching and direction of the rehabilitation counselor. Reasonable accommodations may be needed to assist in the communication process.

E) The individual has demonstrated successful management of and coping with his/her psychiatric symptoms.

F) The individual has the basic needs of food, shelter, and clothing met.

G) The individual is available to participate in vocational services and is not impeded by other obligations (Gloeckler, Surles, & Sheldon, 1993).

If these consumer characteristics were met then the Memorandum of Understanding stated that OMH refer a consumer to VESID via the following processes:

A) Determination to Refer: The mental health provider will determine, using the consumer characteristics, when an individual should be referred for consideration of eligibility for VESID services. There should be consumer involvement and concurrence in the decision to make the referral.

B) Required Referral Information: With the signed release of information form, the mental health provider will forward the following information with a referral to VESID: consumer identifying information, diagnostic assessment, social, educational and work history, current living situation, and reasons for referral at this time.

C) Other Information to be Included When Available: The following information should be provided to VESID by the mental health provider.

    1) Psychiatric Rehabilitation Readiness Determination: This assessment is available through Clinic, Continuing Day Treatment, Partial Hospital and Intensive Psychiatric

Rehabilitative Treatment programs licensed by the Office of Mental Health.

2) Health status overview including a record of Health problems, known medical conditions, or medications which may impact vocationally or educationally.

3) Education and work background.

D) Referral Process: The referral process leads to a determination of eligibility. Consistent with the 1992 Rehabilitation Act Amendments, the eligibility of consumers referred to VESID will be determined as soon as possible, but no later than 60 calendar days after the signed application for services is received at the VESID District Office.

To initiate and facilitate the referral process, the completion of the Interagency Referral Form [SED/VES-1 (5/91)] is required. At this time, the referral process will follow procedures and timelines established in the VESID Access Policy for Contacting and Determining Eligibility for Consumers (Access Policy). The Access Policy establishes that within seven (7) working days after the signed application for services is received at the VESID District Office, VESID will register the consumer on the VESID database and assign a counselor (Gloeckler, Surles, & Sheldon, 1993).

In addition to outlining how OMH may refer a consumer to VESID, the *Memorandum of Understanding* between the two State Offices outlined the processes by which VESID may refer a consumer to OMH. These processes follow:

A) Determination to Refer: VESID may refer individuals experiencing mental or emotional problems to mental health providers when the individual is currently not connected with a mental health treatment system. The consumer must agree to the referral for these services.

VESID may also refer an individual who may be experiencing mental health problems while participating in or completing a vocational or educational program. VESID may make referrals for assessment, treatment, rehabilitation and support.

B) Required Referral Information: VESID will provide the following information when referring an individual to a mental health provider for service: consumer identifying information; reason for referral, whether for assessment, treatment, support or some combination thereof; and indicators of consumer involvement and concurrence in the decisions to make the referral.

C) Other Information to be Provided When Available: VESID will provide the following additional information to support the referral for mental health services, if available: comprehensive assessment, e.g., situational assessment and diagnostic vocational evaluation; Individualized Written Rehabilitation Program (IWRP); and summary of achievement/problems in participating in mental health or vocational services.

D) Referral Process: To initiate and facilitate the referral process, the completion of the Interagency Referral Form [SED/VES- (5/91)] is required. This must be completed along with a signed consent to release information. Once a referral is received, the mental health provider will schedule an initial interview. Upon completion of the interview, the description of services to be provided and a timetable for the services will be shared with VESID, with the consent of the consumer (Gloeckler, Surles, & Sheldon, 1993).

Other interagency systems considerations for VESID and OMH in addition to consumer characteristics and the process for referral were:

A) OMH and VESID will encourage OMH regional offices, community mental health providers and VESID district offices to identify a rehabilitation liaison for persons with mental illness, to expedite referrals and foster interagency cooperation.

B) The release of consumer information between the mental health and VESID service delivery system will be in accordance with the confidentiality guidelines established by each agency and all applicable New York State laws and regulations.

C) This agreement cannot be modified, amended or otherwise changed except by a written statement signed by all parties to this agreement (Gloeckler, Surles, & Sheldon, 1993).

Some of the results of the interagency collaboration between VESID and OMH were reported in the *1993 Amendment to the State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993 and 1994* by the New York State Education Department, Office of Vocational and Educational Services for Individuals with Disabilities (VESID) (Attachment 9.4A, p. 9). In this document it was reported that persons with mental illness under the responsibility comprised "21% of VESID's total caseload; 25% of service users who drop out of service after plans are written or implemented; 17% of people who successfully conclude VESID services and are employed; 15% of people placed in competitive employment; 21% of people placed in sheltered employment; 20% of people placed in supported employment; and 28% of people served by VESID who had some prior experience with higher education."

The *Interim 1994 Title VII State Plan for Independent Living* (The State Education Department & The University of the State of New York, Attachment 9.4A, p. 1) and the *1992 Annual Update to State Plan for*

Independent Living Services for Federal Fiscal years 1991, 1992, and 1993 (The University of the State of New York, Attachment 9.4A, p. 1) both state that "American Indians with disabilities are a part of the underserved population of individuals with disabilities who are racially, culturally and linguistically diverse from the American public." In addition to this it is recognized that "American Indians with disabilities are geographically and culturally isolated from the American public" (The State Education Department & The University of the State of New York, Attachment 9.4A, p. 1). As a result, communication with outside government agencies is limited because independent living programs are generally focused on urban consumer populations. The New York State Education Department also recognizes that communication between American Indian populations and government agencies may be limited by the mistrust and fear of systems and institutions that many American Indians have.

Both the *Interim 1994 Title VII State Plan for Independent Living* (The State Education Department & The University of the State of New York, Attachment 9.4A, p. 1) and the *1992 Annual Update to State Plan for Independent Living Services for Federal Fiscal years 1991, 1992, and 1993* (The University of the State of New York, Attachment 9.4A, p. 2) cited a demographic study carried out by the United States Indian Health Service in 1980. Through this study it was found that 28.2% of all American Indian households subsist below the U.S. poverty level. The study also found that American Indian individuals experience sustained unemployment, with rates that fluctuate between 33% and 85%. "Given this data, Native American individuals are less likely to find viable employment than any other group of individuals with disabilities from a minority population" (The University of the State of New York, Attachment 9.4A, p. 2).

Understanding the probable exclusion yet desiring the eventual inclusion of American Indians with disabilities in vocational and educational programs, VESID initiated the Native American Independent Living Services Research Project. The long term goal of this project was to develop an awareness of VESID and independent living services, and to make these programs accessible on a routine basis to the American Indian population in New York State.

Two surveys were developed in order to assess the needs of American Indian individuals with disabilities. "The first survey was to assess the current status of services being provided to Native Americans from local Independent Living Centers. The second survey of Native American Governments was to identify the nature and prevalence of medical, physical and developmental conditions affecting native American individuals with disabilities" (The University of the State of New York, Attachment 9.4A, p. 2).

The Independent Living Center survey was conducted at 9 of 35 Independent Living Centers in New York State. These nine sites were chosen because of their close geographic proximity to the Native American Nations. Results of this study indicated that only 32 American Indians with disabilities had been served by all 9 of the Centers during their operational history. The amount of time that these centers have been in operation was not provided. "It was also learned that most directors had no knowledge of the Native American culture, nor the character of the Native American Nation government with whom they would be required to communicate to disseminate service information" (The University of the State of New York, Attachment 9.4A, p. 3). Two of the directors had established contact with Native American government representatives but no relationships that would allow for the channeling of program notices developed out of these contacts. The study also found that all directors recognized the cultural differences between American Indians and the American population at large. They expressed some apprehension about being asked to provide services without appropriate cultural training for Center personnel.

The Native American Government Survey results were obtained from three of the Native American Nations. Seven of the eight Native American Nations in New York State were visited. The Poospatuck Indian government did not respond to requests to meet with their representatives. Only three of the Native American nations agreed to participate in the study. These were the St. Regis Mohawk, Seneca Nation, and the Oneida Native American Nation. Four of the seven Native American governments that were visited refused to take part in the survey, citing long standing objection to the enumeration of their people. "However, these Nations requested a thorough briefing on VESID and the independent living program so that the information would be available to Native American individuals with disabilities if they chose to access the services on an individual basis" (The University of the State of New York, Attachment 9.4A, p. 3).

Discussions with the Native American government representatives from the three participating Nations revealed concern that the youth of their Nations receive every opportunity to enter the work force. To help facilitate this three participating Nations indicated a desire to pursue the development of independent living centers to provide services within their own territories to address the need of their people.

To supplement the information gathered through the two surveys the Native American Independent Living Services Research Project received statistical data from the U.S. Indian Health Services, Office of Demographic

Statistics in Washington, D.C.; and the New York State Education Department's Offices of Program Services, Planning, Assessment and Technological Services Information Center on Education, Elementary, Middle, and Secondary Education Administrative and Management Services, and the Bureau of Educational Management Services (The University of the State of New York, Attachment 9.4A, p. 5).

Information on the Indian Health Service death statistics from 1984 to 1988 showed that the leading causes of death among Native American people were heart disease, cancer, diabetes, accident/effects, cirrhosis, cerebrovascular disease, hypertension, and arterial disease. Outpatient statistics from the St. Regis Mohawk and Seneca Nation revealed that the life threatening diseases most frequently treated at their facilities were diabetes, respiratory illnesses, circulatory disease, bone disorders, cirrhosis, and endocrine/metabolic disease. "When the two groups of data were compared, the disease and death statistics demonstrated a relationship between those diseases for which Native American patients most frequently sought treatment and those from which most Native Americans died over period of five years" (The University of the State of New York, Attachment 9.4A, p. 6).

Analysis of statistics from the *System to Track and Account for Children with Handicapping Conditions* (STAC) and *Basic Educational Data System* (BEDS) related to the number and type of individuals with developmental disabilities present within the Native American student population demonstrated that the highest disability incidence occurred in the areas of speech impairment, mental retardation, multiple disabilities, and emotional disabilities. This analysis was done by type of disability over a three-year period. The educational statistics demonstrated that a substantial number of individuals with disabilities were present within the Native American student population.

Based on information compiled from several sources (the Independent Living Center Survey; the Native American Government Survey; supplementary data from the U.S. Indian Health Services, Office of Demographic Statistics in Washington, D.C.; the New York State Education Department's Offices of Program Services, Planning, Assessment and Technological Services, Information Center on Education, Elementary, Middle, and Secondary Education Administrative and Management Services; and the Bureau of Educational Management Services) the **Native American Independent Living Services Research Project** provided VESID with the following recommendations for addressing the needs of American Indians with disabilities in New York:

1) With assistance of VESID staff, additional specific research should be completed by those Native American Nations who have indicated an interest and willingness to develop an Independent Living Center (ILC) program to determine and accurate assessment of their current population and service needs of eligible ILC and VESID consumers.
2) VESID and ILCs should work together to initiate: (a) cultural sensitivity training programs; (b) alternate procedures to assess this culturally different consumer population; (c) identification and resolution of barriers to service; and (d) cooperative efforts for increased and more effective outreach.
3) Current ILCs should be encouraged to increase their efforts to provide greater access to Native American individuals with disabilities and, where appropriate, seek additional fiscal support from all available resources to accomplish this goal.

4) VESID offices should contact Native American Nations to establish a relationship to provide in-service training where requested and outreach to Native American individuals with disabilities.

5) VESID should provide technical assistance to those nations interested in developing independent living services within their communities (The University of the State of New York, Attachment 9.4A, pp. 7-8).

Summary of Existent Databases

U.S. Census Data

The 1990 U.S. Census reported that 62,651 American Indian, Eskimo and Aleut persons lived in New York state (U.S. Department of Commerce and Bureau of the Census, 1992, p. 243). The educational attainment of American Indian, Eskimo and Aleut persons in New York state was reported for 42,389 persons ages 18 and over (U.S. Department of Commerce and Bureau of the Census, 1993, p. 242). Of these 42,389 persons, 11,920 (28%) had at least a high school diploma or the equivalent; 4,993 (12%) had a bachelors degree or higher (U.S. Department of Commerce and Bureau of the Census, 1993, p. 242). The disability status of civilian, non-institutionalized persons between the ages of 16 and 64 years in New York state, including both urban and rural areas as well as reservation and trust lands, was reported for 38,905 American Indian, Eskimo and Aleut persons, resulting in 5,447 (14%) persons identified with a *work disability* (U.S. Department of Commerce and Bureau of the Census, 1993, p. 242).

The U.S. Census defined a person with a *work disability* as a person who "had a health condition that had lasted for six or more months and which limited the kind or amount of work they could do at a job or business. A person was limited in the kind of work he or she could do if the person had a health condition which restricted his or her choice of jobs. A person was limited in the amount of work if he or she was not able to work full-time" (U.S. Department of Commerce and Bureau of the Census, 1993, p. B-35). Of the 5,447 persons who had work disabilities, 2,044 were in the labor force and 2,881 were prevented from working (U.S. Department of Commerce and Bureau of the Census, 1993; p. 242). Detailed information regarding the numbers of American Indian, Eskimo and Aleut persons in New York with disability status are presented in Appendix B.

A total of 6,331 American Indian, Eskimo and Aleut persons were reported to reside on American Indian Reservation and Trust Land in New York state in 1990. Of these, the two largest reservation populations reported were for the St. Regis Mohawk and the Cattaraugus reservations (U.S. Department of Commerce and Bureau of the Census, 1993, p. 2609). These data are available for review in Appendix C.

While the U.S. Census urban and rural data regarding disability status reported above included American Indian, Eskimo and Aleut persons living on reservation and trust lands, the U.S. Census also reported separately the disability status for 3,732 American Indian, Eskimo and Aleut persons between the ages of 16 and 64 years living on American Indian reservations and trust land. Of these persons, 412 (11%) had work disabilities, with 143 (4%) persons in the labor force and 235 (6%) prevented from working (U.S. Department of Commerce and Bureau of the Census, 1993, p. 2583). These data are available for review in Appendix D.

Office of Mental Health Data

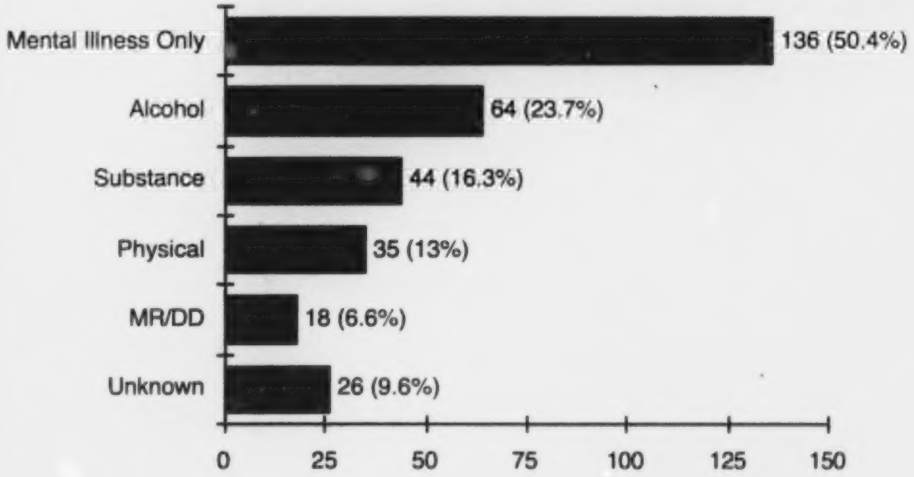
Every two years the Office of Mental Health (OMH) in New York state conducts a one week survey regarding client population characteristics. Of the 145,100 persons surveyed in 1991 by OMH, 365 (.25%) were American

Indian persons. The 365 persons who were served by OMH represented .6% of the total population of American Indians living in New York (62,651). The majority [64% (234)] of the 365 American Indian persons were classified as having a serious and persistent mental illness, while 17% (61) were classified as having *dual diagnosis* (including both a mental illness as well as a chemical abuse problem). Almost a third (31%) of the OMH American Indian consumers received community support services consisting of nonresidential programs such as on-site rehabilitation, day training, sheltered workshop, transitional employment, supported employment, education, intensive case management, psychosocial club or children and youth family support. Of the 365 American Indians served by OMH, 184 (50.4%) were males and 181(49.6%) were females.

Of the 365 American Indians served by OMH, 270 (74%) were between the ages of 18 and 64. The age breakdowns available from the OMH data included "18 to 34" [43% (117)] and "35 to 64" [57% (153)]. Subsequent discussion of the OMH data will focus on the client characteristics of this working age population, with the assumption that these are the individual most likely to make use of vocational rehabilitation services. Slightly more than half [50.4% (136)] of the 270 American Indian consumers between the ages of 18 and 64 were described as having a "mental illness only" (see Figure 1). A little less than half of the OMH American Indian consumers [40% (108)] had either alcohol or substance abuse problems. It was not clear whether those with physical disabilities also had additional disorders such as alcohol or substance abuse problems.

Figure 1

Disabilities of OMH American Indian Working-Age Clients During 1991 Survey Week (N=270)



Note: Since an individual client may be included in more than one category, the sum of categories exceeds total N.

The diagnostic categories of the OMH American Indian consumers are listed in Figure 2a, with schizophrenia being the most common mental illness [39.3% (106)] diagnosis. Of the 270 American Indian consumers between the ages of 18 and 64 the majority (66.3%) were classified as having either a severe and persistent mental illness (SPMI) or serious emotional disturbance (SED) (see Figure 2b).

Figure 2a

Diagnosis Categories of OMH American Indian Working-Age Clients During 1991 Survey Week (N=270)

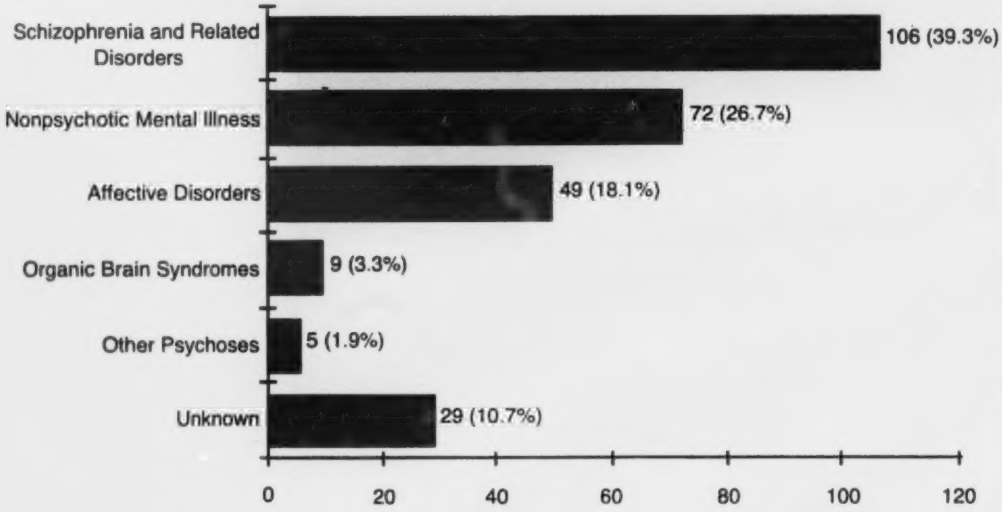
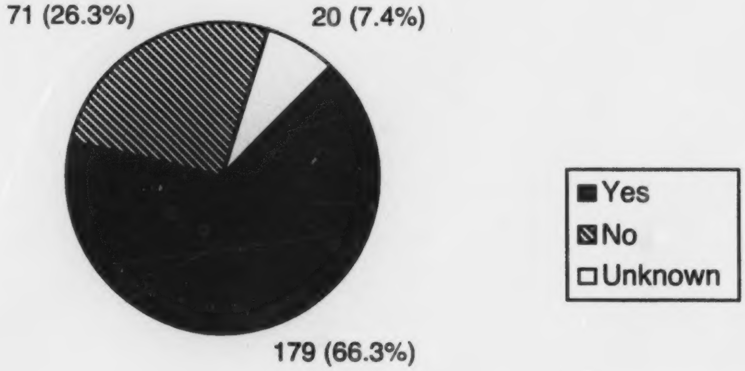


Figure 2b

SPMI/SED Status of OMH American Indian Working-Age Clients During 1991 Survey Week (N=270)



Vocational and Educational Services for Individuals with Disabilities Data

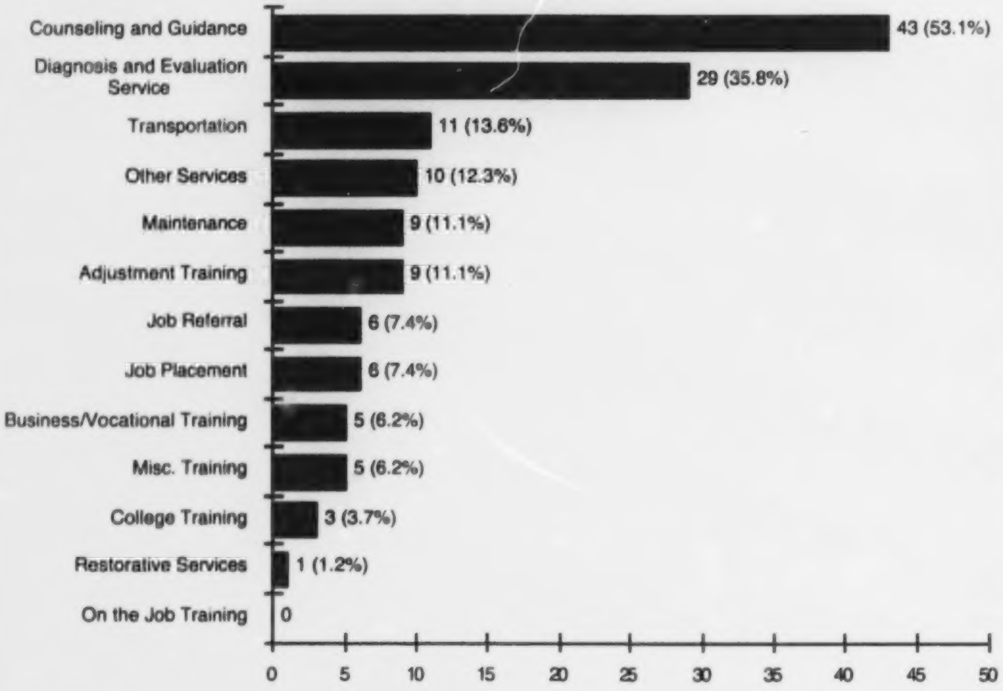
Data from the office of Vocational and Educational Services for Individuals with Disabilities (VESID) were provided by the Rehabilitation Services Administration (RSA).

American Indian applicants. In 1991, 81 American Indian consumers applied for services with VESID. The majority of these applications [93.8% (76)] were to General VESID agencies. The remainder of the applications [6.2% (5)] were to VESID Blind agencies. Of the 81 applicants there were slightly more males (58%) than females (42%). Thirty-five (43.2%) of the applicants had never been married and 23 (28.4%) were married at the time of application. Only 28 (34.6%) of the 81 American Indian consumers had finished high school. The mean for the highest grade completed for this group of consumers was 11.2 years. The mean years of age was 40. The 81 American Indian applicants included people with both severe and non-severe disabilities. There were 44 (54.3%) applicants with non-severe disabilities and 37 (45.7%) applicants with severe disabilities. Approximately 76% of the applicants with severe disabilities were accepted for services whereas only 34% of the applicants with non-severe disabilities were accepted.

There were 13 different services provided to the VESID applicants (see Figure 3). Some consumers received more than one of these services, therefore the sum of the frequencies of services provided is more than the total number of American Indian consumers. The average amount of time spent in services was 1.3 years, with a median and mode service duration of one year.

Figure 3

Frequencies of Services Provided to VESID American Indian Applicants in 1991 (N=81)

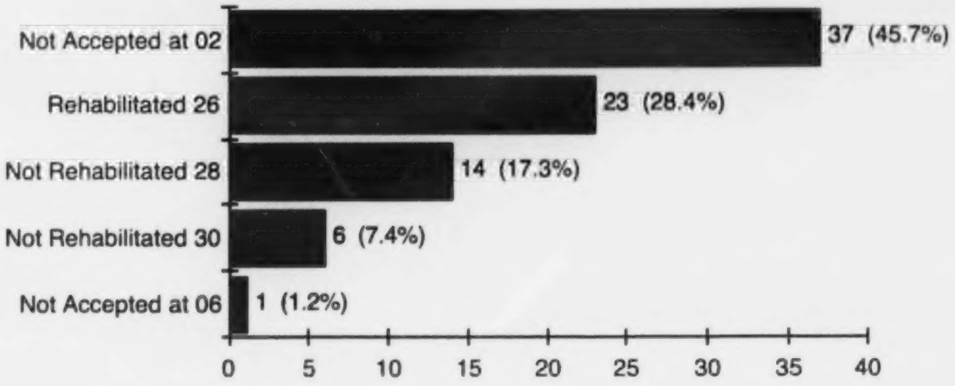


Note: Some consumers received more than one service, therefore the sum of the frequencies of services provided is more than the total N.

In terms of the type of closure obtained with the 81 applicants (VR Status Code 02), *almost half were not accepted for services* (at application, VR Status Code 02 or after extended evaluation, VR Status Code 06), *approximately a quarter were accepted for services, but closed unsuccessfully* (VR Status Codes 28 and 30), *and a little over a quarter were closed successfully rehabilitated* (VR Status Code 26) (see Figure 4).

Figure 4

Type of Closure of VESID American Indian Applicants in 1991 (N = 81)



The reasons for closure of the 38 American Indian VESID applicants *not accepted for services* (at VR Status Codes 02 and 06) included: service refusal, inability to locate, transfer to another agency, handicap too severe, did not have a handicap or disabling condition, one death and all other reasons (see Figure 4a). Of the twenty American Indian VESID applicants accepted for services but closed unsuccessfully (VR Status Codes 28 and 30), reasons for closure included inability to locate, services refused and other unidentified reasons (see Figure 4b).

Figure 4a

Reasons Given for VESID American Indian Applicants *Not Accepted* for Services in 1991 (N = 38)

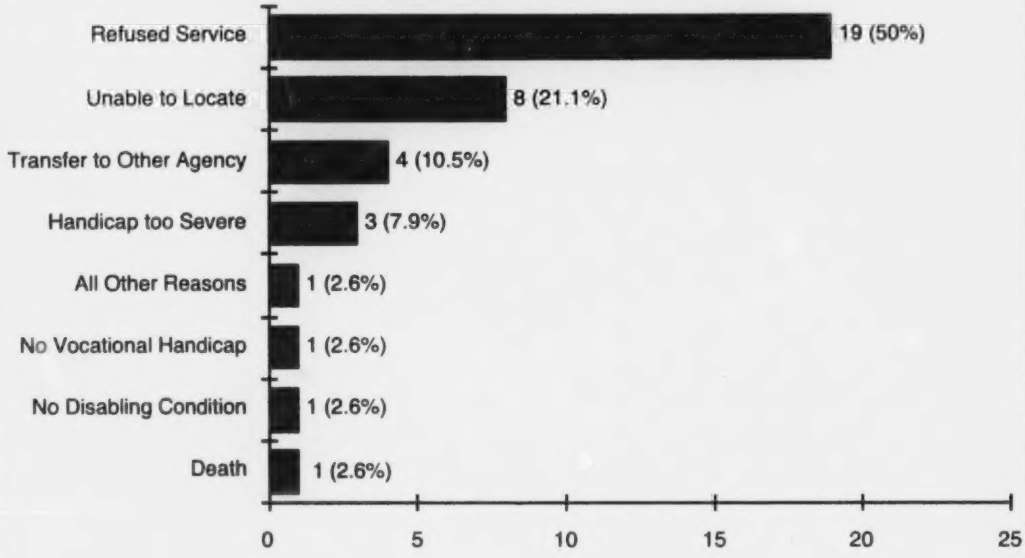
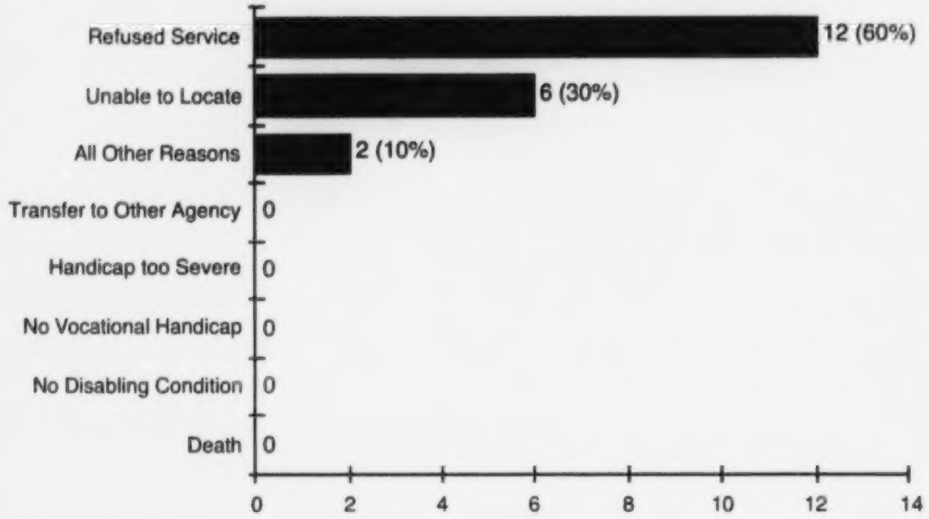


Figure 4b

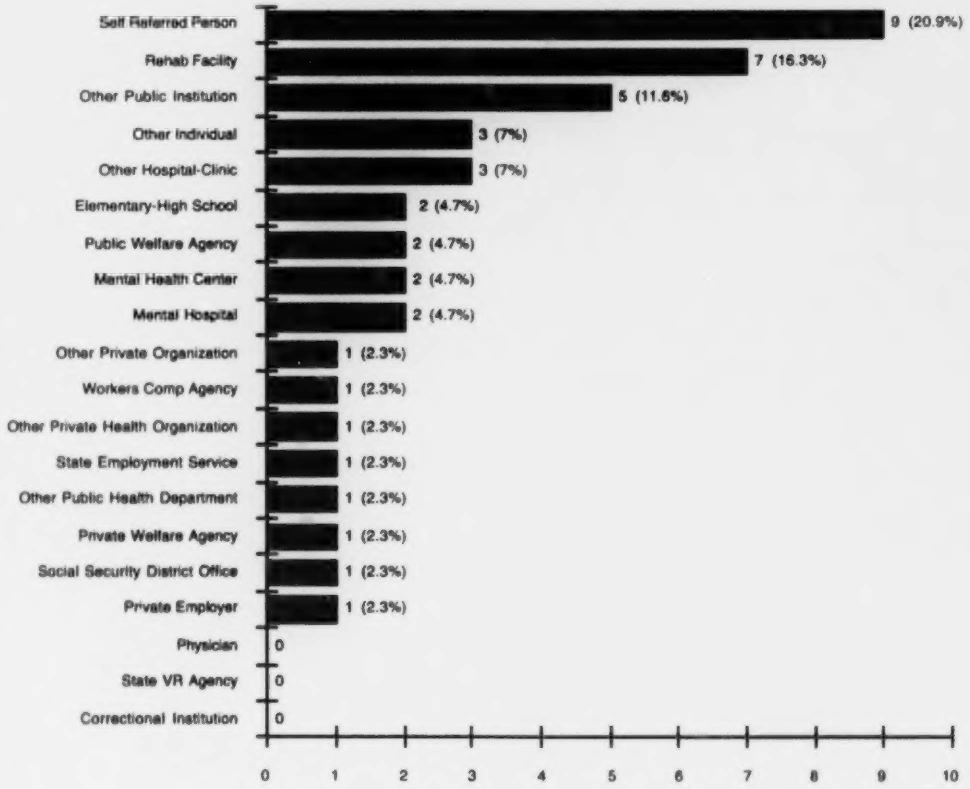
Reasons for Closure of VESID American Indian Applicants Accepted for Services but *Not* Rehabilitated (N = 20)



American Indian applicants accepted for services. There were 20 different referral sources for VESID American Indian applicants accepted for services with the most common referral source (21%) being self-referral (see Figure 5). Hereafter, American Indian applicants accepted for services will be referred to as *consumers*. It is interesting to note that the most common referral source for the 38 applicants that were not accepted for services was also the self-referral, with 26.3% (10) of the "not accepted" persons having been self-referrals.

Figure 5

Referral Sources of VESID American Indian Applicants Accepted for Services in 1991 (N=43)



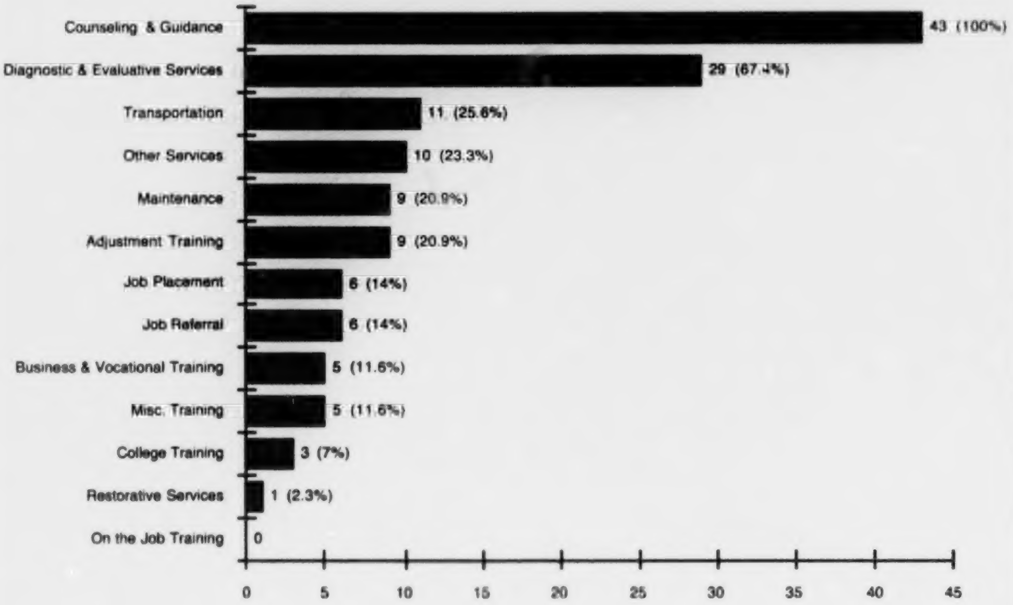
Services delivered to VESID American Indian consumers are listed in Figure 6. Due to some VESID consumers having received more than one service, the data represent the frequency of services delivered and not the number of VESID consumers who received them.

The agencies that delivered services to VESID American Indian consumers included educational institutions, business/vocational schools, hospitals, health organization agencies, rehabilitation facilities, individuals

BEST COPY AVAILABLE

Figure 6

Frequencies of Services to VESID American Indian Consumers in 1991 (N= 43)



Note: N = Total number of consumers. Many consumers received more than one service.

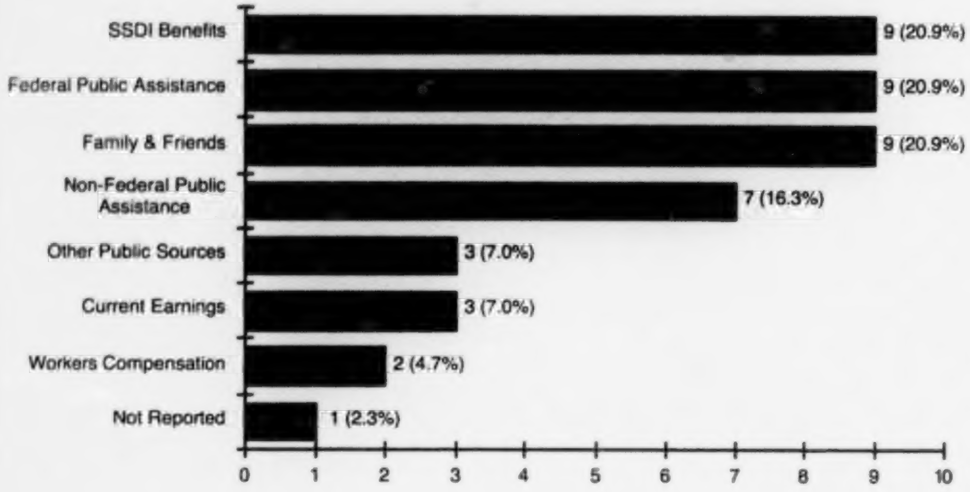
and private agencies. Private individuals provided most [28.4% (23)] of the services to the 81 VESID American Indian consumers. Seventeen (21%) of the consumers were provided service through a rehabilitation facility. The remainder of the services were provided by other private agencies [13.6% (11)], business/vocational schools [7.4% (6)], health organization agencies [7.4% (6)], hospitals [3.7% (3)] and educational institutions [3.7% (3)].

The work status at application of the 43 VESID American Indian consumers was reported for those that were accepted for services. Slightly over three-quarters [76.7%, (33)] of the consumers were not working when they were accepted for services. Work status' included work in the competitive labor market [9.3% (4)], trainee status [4.7% (2)], student status [4.7% (2)], homemaker [2.3% (1)] and sheltered workshop employee [2.3% (1)]. Of the four persons for whom weekly earnings at application were reported, one had a weekly earning of $50, one $80, one $150, and one $458. The primary sources of economic support for consumers at application were, as the Figure 7 demonstrates, SSDI benefits, federal public assistance, and family and friends were the three most common sources of support.

The major disabling conditions of the 81 American Indians who *applied for VESID services* included blindness, deafness, orthopedic disabilities, mental retardation and behavioral health diagnoses. The major disabling conditions of the 43 American Indian consumers are presented in Figure 8a. In contrast, the major disabling conditions of the applicants *not accepted* for services are presented in Figure 8b.

Figure 7

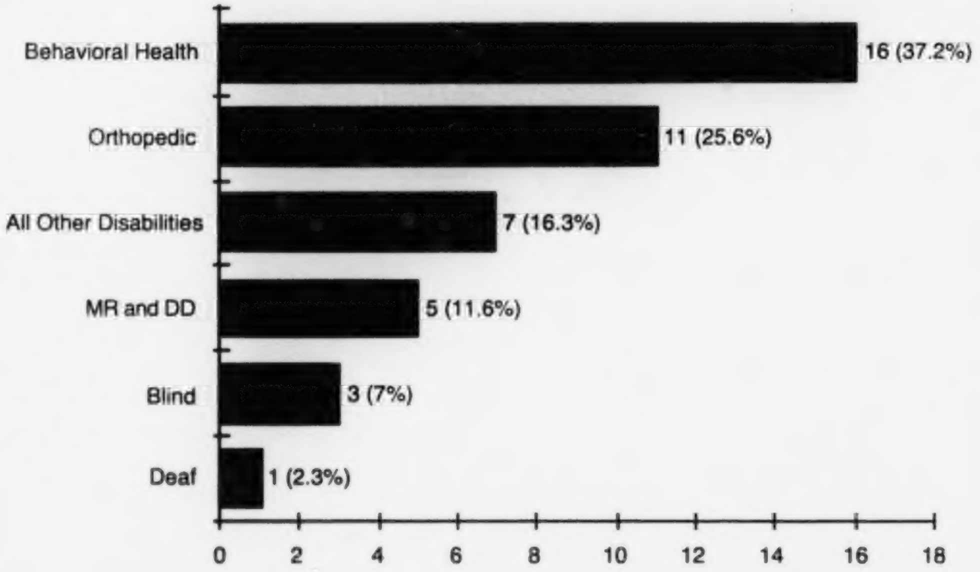
Primary Source of Support at Application of VESID American Indian Applicants Accepted for Services (N = 43)



Note. The primary source of support for one person was not reported.

Figure 8a

Major Disabling Conditions of VESID American Indian Consumers in 1991 (N = 43)

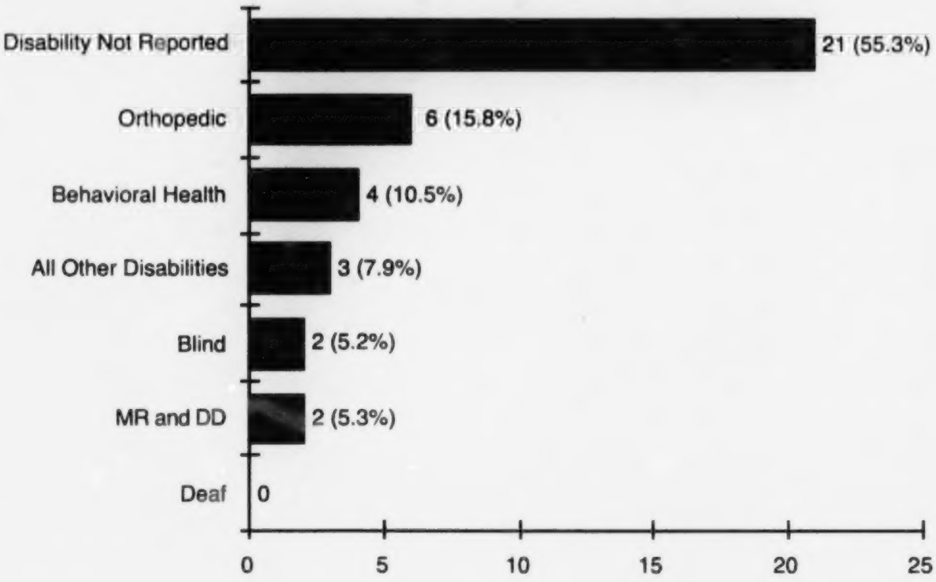


Of the 43 VESID American Indian consumers, 23 (53.4%) were successfully rehabilitated. Their disabilities included blindness, deafness, orthopedic disabilities, psychotic disabilities, alcohol abuse disorders, 'other' mental illness, mild mental retardation, and an unspecified disability (see Figure 9).

The occupations of the American Indian persons at closure were reported for the 23 VESID consumers who were successfully rehabilitated. These occupations and the number of persons that were placed in each occupation are displayed in Figure 10. Work hours at closure averaged 33.26

Figure 8b

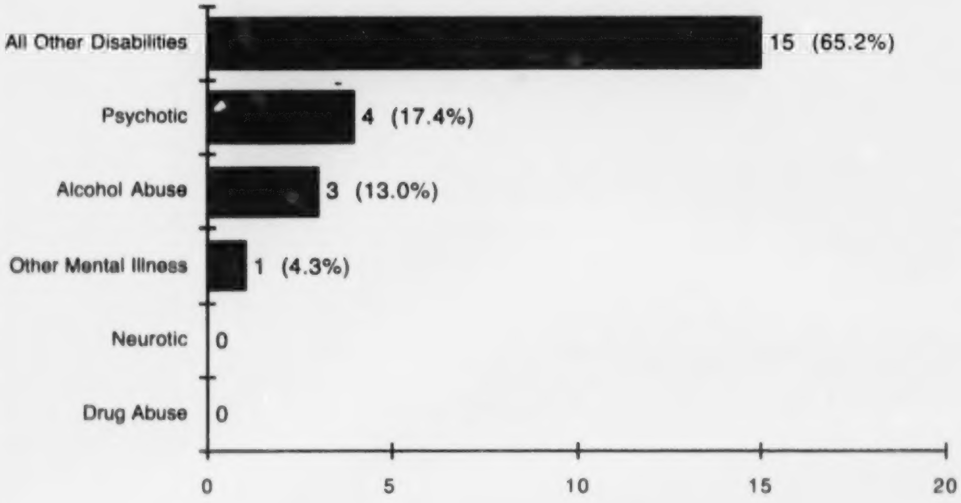
Major Disabling Conditions of VESID American Indian Applicants *Not Accepted* for Services in 1991 (N = 38)



hours with a standard deviation of 11.31. The 23 successfully rehabilitated American Indian consumers were either employed in sheltered workshops [34.8% (8)] or the competitive labor market [65.2% (15)].

Figure 9

Major Disabling Conditions of VESID American Indian Consumers Successfully Rehabilitated in 1991 (N = 23)



American Indian behavioral health applicants. Referring to Figures 8a and 8b presented earlier shows that 16 of the VESID American Indian consumers and 4 of the VESID American Indian applicants not accepted for services had behavioral health diagnoses. Of the 81 American Indian persons who applied for services with VESID, one-quarter [25% (20)] had behavioral health diagnoses. Of these 20 persons, the majority [80% (16)] were accepted for services. Disabling behavioral health conditions included psychosis, alcohol abuse disabilities, drug abuse disability, other mental illnesses and neurosis (see Figure 11). Of the four consumers with behavioral health diagnosis that were not accepted for services three (75%) carried a diagnosis of alcohol abuse (see Figure 12).

Figure 10

Occupations at Closure of VESID American Indian Successfully Rehabilitated Consumers in 1991 (N = 23)

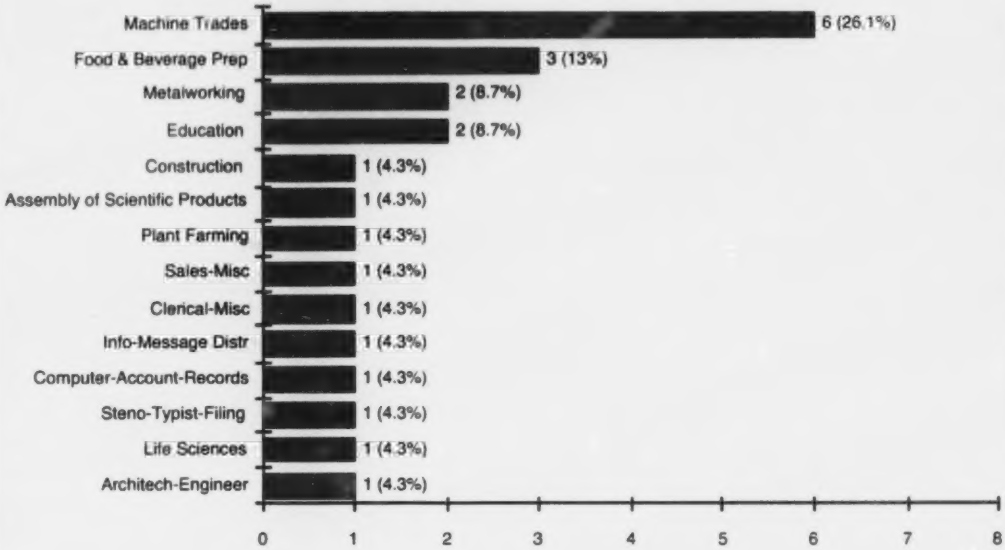


Figure 11

Behavioral Health Diagnoses of VESID American Indian Applicants Accepted for Services in 1991 (N= 16)

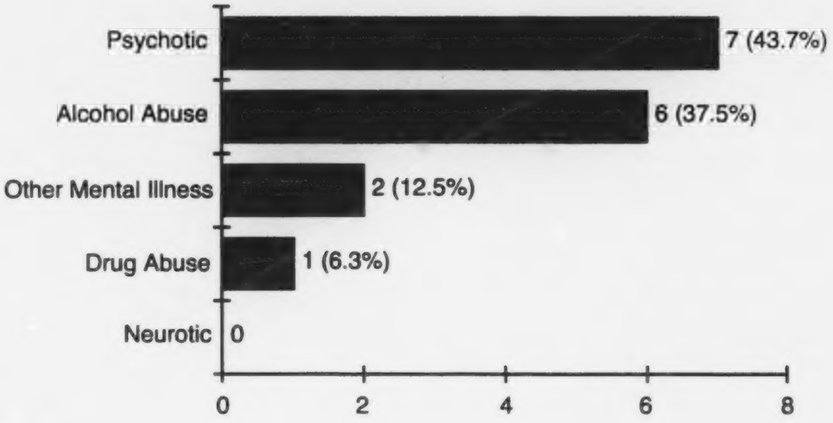
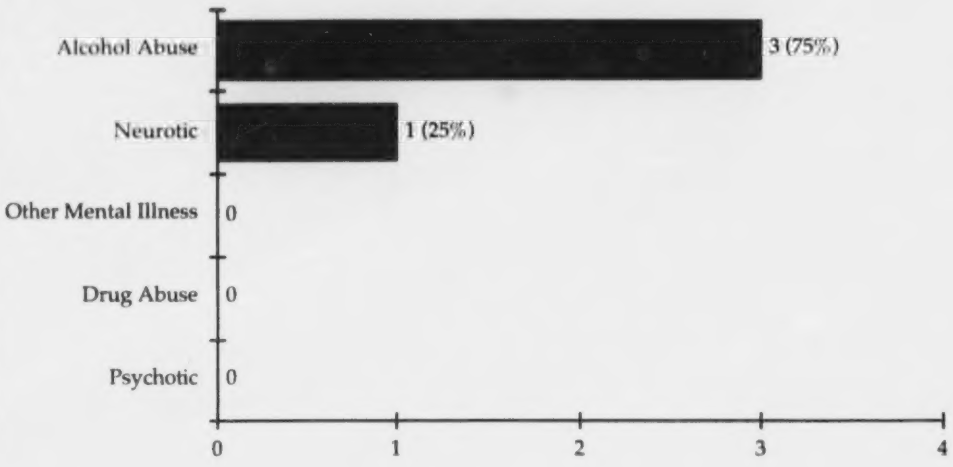


Figure 12

Behavioral Health Diagnoses of VESID American Indian Applicants *Not Accepted* for Services (N= 4)

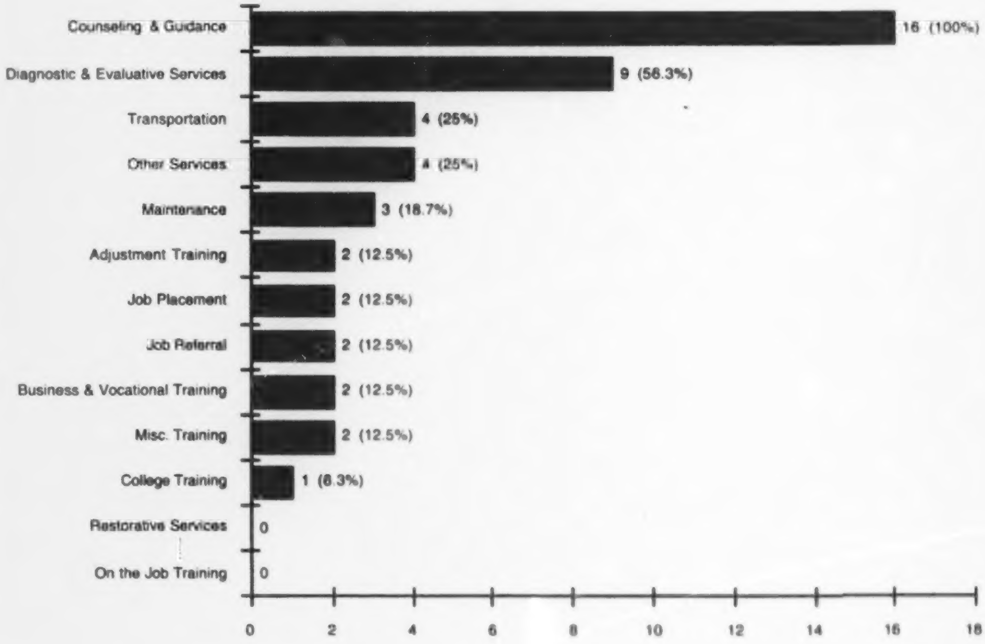


The services that were provided to the 16 VESID consumers with behavioral health diagnosis are listed in Figure 13. The subtotals presented in this figure total more than the total number of consumers due to some consumers receiving more than one of the services provided.

The institutions which provided services to the 16 VESID American Indian consumers with behavioral health diagnoses included educational institutions [5% (1)], business/vocational schools [10% (2)], hospitals [10% (2)], health organization agencies [10% (2)], rehabilitation facilities [30% (6)], individuals [40% (8)] and private agencies [20% (4)].

Figure 13

Frequencies of Services Provided to VESID American Indian Behavioral Health Consumers in 1991 (N= 16)

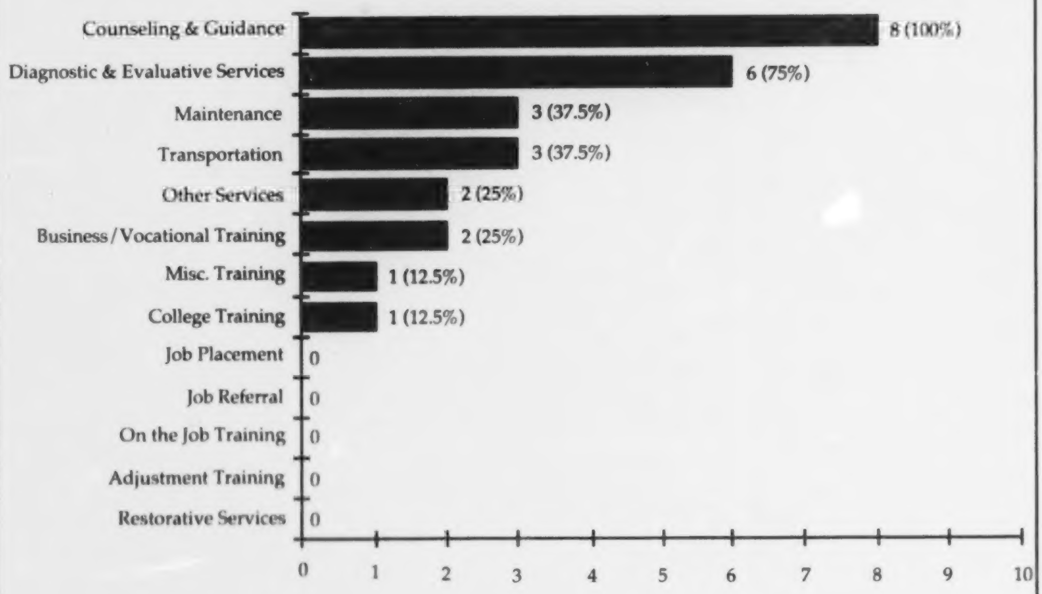


Note: N = Total number who received services. Many consumers received more than one service.

Half (8) of the 16 American Indian consumers that had behavioral health diagnosis were successfully rehabilitated. Four (50%) of these eight successfully rehabilitated individuals had psychotic disorders, three (37.5%) had alcohol abuse problems and the diagnosis of one (12.5%) person was listed as "other mental illness." The services that were provided to the eight VESID American Indian consumers that were successfully rehabilitated and the eight VESID American Indian consumers that were not successfully rehabilitated are listed in Figures 14a and 14b.

Figure 14a

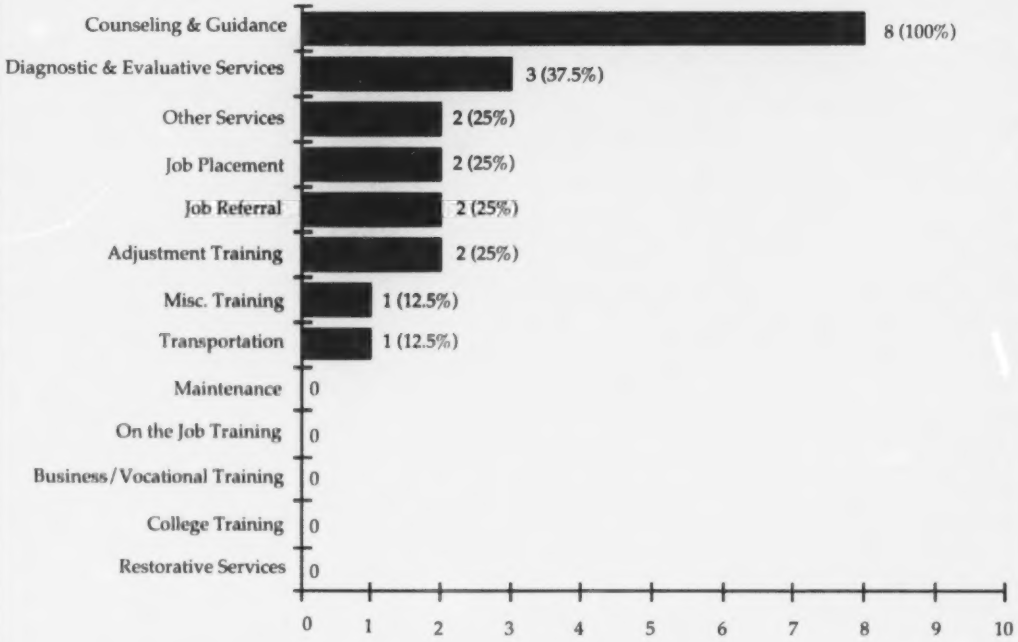
Frequencies of Services Provided to Rehabilitated VESID American Indian Behavioral Health Consumers (N=8)



Note: N = Total number who received services. Many consumers received more than one service.

Figure 14b

Frequencies of Services Provided to VESID American Indian Behavioral Health Consumers that were *Not* Rehabilitated (N=8)



Note: N = Total number who received services. Many consumers received more than one service.

Eight (50%) of the sixteen American Indian consumers that had behavioral health diagnosis were provided the services listed in figures 14a and 14b from private individuals. Rehabilitation facilities provided six (37.5%) consumers that had behavioral health diagnosis with services. The remainder of services to consumers that had behavioral health diagnosis were provided by other private agencies [25% (4)], business/vocational schools [12.5% (2)], health organization agencies [12.5% (2)], hospitals [12.5% (2)], and educational institutions [6.3% (1)]. The occupations of the successfully rehabilitated VESID American Indian consumers with behavioral health diagnosis at closure are listed in Table 1. The majority of the eight American Indian behavioral health consumers that were successfully rehabilitated [75% (6)] were employed in the competitive labor market. Two individuals (25%) were employed in a sheltered workshop.

Table 1

Occupations at Closure of Rehabilitated VESID American Indian Behavioral Health Consumers in 1991 (N=8)

Occupation	n	%
Machine Trades	2	25
Assembly of Scientific Products	1	12.5
Metal Working	1	12.5
Plant Farming	1	12.5
Food & Beverage	1	12.5
Computer Accounting and Records	1	12.5
Architecture/Engineering	1	12.5

Qualitative Data

Research activities in 1994 included qualitative interviews with key informants to enhance understanding of the VR service delivery needs of American Indians with behavioral health disorders in New York State.

Behavioral Health

One key informant was Mr. Lawrence Williams, Project Director of **Choices Unlimited** in New York City. **Choices** operated "on the premise that people who are homeless and mentally ill are just like anyone else, they have the same aspirations as everyone else: finding a place to live, a job, learning and socializing. The mission of the program is to assist program members to realize these goals" (**Choices** informational handout). In approaching people with behavioral health disorders as "people first," Mr. Williams commented that the ideal treatment or intervention program allowed for *"flexibility, choice, different alternatives. . . . [People] need a program that isn't going to bore them to death."*

An American Indian consumer participant with **Choices,** "Alan," shared his story:

> Alan's maternal grandfather was Pima and his maternal grandmother was Mohawk. His father is Puerto Rican, but left the family when Alan was one year old. Alan has one brother who is 17. Alan stated, *"I come from a broken family and **I have no definite job skills to make me live on my own**. My grandmother has been through divorces, my mother has had three different men; the last one was killed by gunshot."* Alan reported that his mother was involved with Indian community when he was young, but now she isn't. *"It was a strong part of my life when I was younger."*
>
> Alan is now 24. In addition to participating with Choices, he is a client of Pathways to Housing, Fountain House, and Independence Support Center. In 1992, Alan was a client of VESID. VESID assisted him in job training, specifically building-maintenance. Alan was happy with the training; he liked working with the tools and the machinery. Under VESID sponsorship, Alan completed four months of the six-month job training. Alan reported that because he attempted suicide during the time he was in job training, he was no longer involved with VESID. He explained, *"I had special feelings for a*

young woman there [at training site], but she didn't want to be with me."

Alan further explained the 1992 suicide attempt was his first--*"before that, I had a lot of temper tantrums and physical outrages. I was angry with my mother, women. I'm not angry with women now; the anger just naturally went away."* Alan has no communication with mother--*"She doesn't have a phone. I wish I had more of a chance to see her."* Alan has received services since 1984 for *"physical outrages"* and was hospitalized for 14 months. He explained, *"I didn't like myself."* Of hospitalization, Alan commented, *"Very, very bad--a lot of violence among those in the hospital."*

When asked about his current level of service delivery, Alan responded, *"The most important thing about the services I receive now is to make sure that I keep my apartment.* ***I live alone; actually, I don't like living alone. I feel kind of lonely.*** *The alternative is that if I don't keep my apartment, I go homeless again. Living homeless is very bad--no food, no money, no care, no love. I lived homeless about one month. At Independence Support Center (ISC), it's a drop-in center, mainly hanging out. At Fountain House, I spend my time doing horticulture. I would recommend the ISC as the first place for someone to go to. I go every two weeks to St. Luke's for medication/injection. I don't like taking medication--I take it because it tranquilizes my anger. [I have a] case manager. He sees to it that I get my money, that I get to programs, special trips, for example, the Great Adventure Amusement Park in New Jersey."* In general, Alan reported being *"happy"* with his current level of services.

When asked about consumer strategies for seeking VR services or employment, one key informant, a non-Indian consumer participant with **Choices** commented:

1. Read Americans with Disabilities Act

2. Make his vocation fit his disabilities, *e.g. if a person hears voices, he probably shouldn't be a train conductor. He'll hear "Keep on going" and go right on through the station.*

3. Teach the client how he should approach a service provider. The basic problem a client with mental illness has to do with his rights. Needs to find out about involuntary commitment and medication. Teach the client to approach a service provider as any other service or shopping that you might do. ***Look for professionals that you can get along with--that you feel comfortable with****--whether case manager, social worker, psychotherapist or psychiatrist or vocational counselor even a lawyer. Someone who understands you--understands what you are saying. This is useful for persons who come from cultures different from the mainstream--even more important. The services were designed to fit the mainstream.*

4. Associate with others in your same circumstances to assist in finding a program that meets your needs.

American Indian Community

Health and human service providers were interviewed in one American Indian community, the Akwesasne Reservation of the St. Regis Mohawk Tribe in northern New York State. The Akwesasne interviews resulted in a number of findings that contributed to the design and content of a two-day training symposium conducted in Syracuse, New York in November 1995 (see Project Action Outcomes, below). For example, service providers on the Akwesasne Reservation indicated a keen interest in the affirmative industries and supported employment VR service delivery models. **Informants indicated that not only individuals with severe psychiatric disabilities, but also persons with developmental disabilities did not want to leave the reservation for services, nor for employment opportunities**. One mental health professional who worked primarily with American Indians who had severe and persistent mental illness commented: *"[My clients] don't have an interest in going off community. Local community is their network. Voc rehab in Malone is not their place, not their people. . . . Culture translates as proximity."*

For persons with severe disabilities, the affirmative industries model or supported **employment models delivered on the reservation were proposed as more acceptable VR service delivery models**. Such local small businesses as bakeries were identified as needed businesses and therefore possible alternatives for affirmative industries for individuals with disabilities on the Akwesasne Reservation. In addition, interviewees identified resources on supported employment, job coaching, and school-to-work transition as ones where they would very much like additional print resources and on-reservation training of existing and potential indigenous professionals to provide these services. It was also suggested that if such **an inter-coordinated array of services** were made available on the reservation, that its use **should expand beyond the mental health population to services that could be provided across a variety of disability groups**. For example, one key informant, a human services professional commented: *Lots of our families are in trouble with alcohol, drugs, violence. Alcohol and drugs are really bad--crack.* Concern was also expressed in St. Regis that perhaps there was a common etiology among some disabling conditions, for example, the influence of environmental factors such as the land fill that drains into the St. Lawrence river (Selikoff, Hammond, & Levin, undated) that should be addressed by a comprehensive and integrated service system.

Public Vocational Rehabilitation

Qualitative interviews with vocational rehabilitation staff in the Malone VR regional office; which serves the Akwesasne Reservation, indicated a sincere interest in the provision of services to Akwesasne. The counselor interviewed, however, indicated that there were not many individuals who came to the VR Agency office itself for services, but rather service intervention appeared to more often be effective when counselors went onto the reservation to assist in the identification of needs and subsequent provision of services. The counselor stated, for example: *"One thing I think I need to do is go back to a regular schedule.* ***I think I need to make myself available--I could bring my other work with me and just be there. . . . It would make things better if I was more available.*** *People can't always keep their appointments--family issues may come up; transportation."* When asked to describe American Indians with severe and persistent mental illness, the counselor stated, *"Difficult, difficult cases. . . .* ***I really want to learn [to better work with American Indians]; I even listen to the Mohawk radio station so I can learn."***

DISCUSSION AND PROJECT OUTCOMES

In review, the purpose of this research was to: (1) examine the level of VR services and mental health services provided in New York State to American Indians with behavioral health diagnoses, (2) assess whether or not additional services were needed to ensure successful VR outcomes, and (3) identify opportunities to establish and/or strengthen collaborative programs between VESID and the New York State OMH. The paucity of Indian people with behavior health diagnoses represented in the service populations reviewed in this research leads to serious questioning of the level of services being provided. Again, the United States 1990 census reported there to be 5,447 American Indians with disabilities in New York State; of these, 2,881 (53%) persons with disabilities were prevented from working.

In theory, if services are (a) desired by, (b) available to, and (c) necessary for persons with disabilities prevented from working, it would be reasonable to expect the number of American Indians who applied for services from the public VR program to be somewhere nearer 2,881. Yet, the RSA data revealed that VESID had 81 American Indian persons apply for VR services, which constitutes 2.8% of the total American Indian persons with disabilities that prevent them from working. Additionally, only 23 of these 81 persons were rehabilitated. Thus, **approximately .8% (less than 1%) of all the American Indian persons in New York State with disabilities which prevented them from working were rehabilitated in 1991.**

In the same year, 1991, OMH data indicated that 179 American Indians of working age were served who had a severe and persistent mental illness--this is more than twice the number who applied for VESID services. While OMH data did not indicate employment status, it is doubtful that all of their clients would have been employed. Thus, given the baseline information regarding American Indians with disability, and specifically those with behavioral health diagnoses, it would appear that the level of public VR service delivery to American Indians falls well below the need. Specifically, of the 81 American Indians who applied for VESID services in 1991, 43 (51%) were accepted for services. Of these 43 individuals, 16 (37%) had a behavioral health diagnosis. Of the 16 individuals with a behavioral health diagnosis, 8 were closed as rehabilitated. Using the OMH data as baseline information, this would indicate that only 4% of the known American Indians with behavioral health diagnoses were rehabilitated into employment.

American Indians with Behavioral Health Diagnoses

Given the very small number of Indian people who were served successfully by the public VR system in 1991 (8 individuals), the focus this discussion centers on the level of service delivery. Some of the VESID referral requirements, as noted earlier in this report (see pp. 16-17), would appear to be exclusionary rather than inviting to American Indians. For example, why should the individual be required to have shelter before seeking vocational services, if in fact, having work would enable one to obtain shelter? Perhaps participation in vocational services would assist/motivate the Indian persons with a behavioral health diagnosis to obtain basic needs such as shelter and clothing. What exactly is meant by the referral requirement that the individual must be "available to participate in vocational services and is **not impeded by other obligations**?" (emphasis added). Would an American Indian in Albany who needed to return to the reservation to deal with family matters for a short time be considered "impeded by other obligations?"

Of the 16 American Indians with behavioral health diagnoses found eligible for VR services during 1991, the plurality [44% (7)] were identified as *Psychotic*, followed by over a third [38% (6)] identified as having a problem with *Alcohol Abuse* (see Figure 11).

Conversely, of the four individuals found ineligible for services, the majority [75% (3)] were identified as having a problem with *Alcohol Abuse* (see Figure 12). All of the 16 VESID consumers received counseling and guidance services. Twice the number of those rehabilitated versus those not rehabilitated (6 compared to 3) received diagnostic and evaluative services (see Figures 14a and 14b). Rehabilitated consumers also received services such as maintenance, business/vocational training, and college training. Consumers *not* rehabilitated received job placement, job referral, and adjustment training. Individuals from both populations received transportation services.

Service delivery through OMH for American Indians with behavioral health diagnoses included a variety of community support services related to rehabilitation such as transitional employment, supportive employment, and psychosocial clubs. Unfortunately, the research team was not successful in obtaining qualitative data from an OMH key informant who could have provided information regarding (a) the actual working relationships between OMH and VESID, (b) actual patterns of referral to VESID, and (c) case file information regarding OMH clients served by VESID.

Considerations Regarding Level of VESID Service Delivery

Given that only approximately .8% of American Indian persons with disabilities in New York state were rehabilitated in 1991, what is to be concluded about the other 99.2%? It is possible that American Indians with disabilities in New York State **are not aware of VR services**, or **are not aware that they may apply for services**. One key informant, a consumer of VESID, explained to the PI that he had no idea self-referral to VESID was possible and had only recently had success in finding an agency that would refer him to VESID. Other reasons American Indians may not receive VR services include the possibility that they **may not have feasible transportation** to VR offices, may not have telephones in order to maintain necessary communication with VR personnel, **may be receiving services from other**

agencies, may not wish to be rehabilitated, may feel uncomfortable in the VR setting, or other unknown reasons.

No doubt, however, part of the problem in serving American Indians is that they are statistically a very small population--easily lost in a large bureaucracy. It would take a dedicated, focused, intense effort to find American Indians and to respond to their individual and cultural needs. As Usdane (1993) has commented:

> Public funding has a hard time keeping up with the elastic needs of people; too often, individual needs are batch-processed by service systems unwilling to be imaginative about idiosyncratic solutions. It is still almost universally the case that funding sources tend not to reflect the wide variety of needs within the system. Instead, they maintain extremely specific eligibility requirements which suggest that service needs are open to neat sorting out into one of a handful of program types. Such boundaries can easily lead to decisions that people with disabilities are ineligible for his or that service, creating widespread potential for people to fall through the cracks and receive services that are poorly suited to their needs or, worse, no services at all (p. 31).

Indeed, according to Ross and Biggi (1986) "experience has taught us that programs and systems developed for the normative and/or dominant culture do not necessarily meet the needs of minority disabled persons" (p. 39). Given a variety of concerns stemming from the level of service delivery available to American Indians with behavior health diagnoses in 1991, it would appear to be important to further consider cultural concerns as regards accessing public VR services.

Cultural considerations. One top-level VESID administrator informed the PI that VESID did not consider ethnicity a factor when working with consumers. A recent publication of the American Psychological Association (APA) reported that "a 'colorblind' approach to combating racism may sound appealing, but it is replete with pitfalls" (Seppa, 1996, p. 15). In reporting on an APA congressional forum on racism, Seppa quoted Dr. Dolores BigFoot as saying, "We know that, through our tribal identification, Indian people have better mental health and better healing pathways. When we eliminate that and eliminate who they are as Indian people, we eliminate their identity" (p. 15).

Interestingly, one key informant of this study, when asked how he might explain the large percentage of public VR consumers who "refused services" either at application or after eligibility was determined (see Figures 4a and 4b) commented: *"Cultural sensitivity pops to mind. Why did these people refuse services? Is it that they can't relate to the services? What are the workers like? What are the staff like? Did they give it a second shot? On the part of the agency, more should be going on. More outreach--a special effort. American Indians are entitled to services just as much as anybody else."* The comments and observations of this key informant are somewhat different than that of public VR counselor who stated in regard to working with American Indians: *"When they want services, we give them services."*

In a their study of the New York public VR delivery system, published a decade ago, Ross and Biggi (1986) found that "'refused services' was the primary reason for closure in 1982 and 1983 for white clients while 'failure to cooperate' more often predominated as the primary reason for closure for nonwhite clients in 1981 and 1983" (p. 39). Of this finding Ross and Biggi asked, "Does 'failure to cooperate' as a reason for closure represent an ethnic bias or a legitimate reason for closure . . .?" (p. 45). They called for further research stating, "frequent reasons for closure such as 'failure to cooperate' and 'refused services' may need further study since there is no explanation for what these terms really mean for a given client or group of clients" (p. 42). Thus while a decade later, nonwhite consumers are also refusing services as the primary reason for VR closure, the meaning(s) behind this terminology are still unknown.

In a report of the mental health needs of urban American Indians in New York City (American Indian, 1993), researchers commented that "cultural barriers to American Indians receiving mainstream health care are difficult to measure and are often the most difficult to remove" (p. 5). However, at a minimum, the American Psychiatric Association's (1994), *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) states that "it is important that the clinician take into account the individual's ethnic and cultural context" (p. 843). Specifically, in terms of a behavioral health disorder that constitutes a severe and persistent mental illness such as Schizophrenia, the DSM-IV states that "clinicians assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural differences into account. Ideas that may appear to be delusional in one culture may be commonly held in another. . . ." (p. 281). [For an in-depth discussion of cultural concerns and behavior health disorders, see also, Basic Behavioral Science Task Force, 1996].

In discussing cultural issues from a rehabilitation perspective, Middleton, Flowers, & Zawaiza (1996) wrote:

> Achieving multiculturalism requires that divisiveness be placed aside and a new consensus be formed . . . . Ultimately, rehabilitation organizations and leaders must be molders of a [new] consensus . . . .

> Positions in rehabilitation based on cowardice ask the question, Is it safe? Expediency asks the question, Is it polite? Vanity asks the question, Is it popular? Yet conscience must ask the question, Is it right? There comes a time when one must take a position that is neither safe, polite, nor popular. One must take a position because it is right, and that is where we find ourselves today (p. 27).

According to Ross and Biggi (1986), "The apparent discrepancy between the percentage of non-white disabled persons in New York State and the percentage of these persons being served . . . indicates the need for a greater outreach effort by the New York Vocational Rehabilitation agency to reach out to non-white populations within the state" (p. 40). Further, these researchers observed that "while some 45% of the working aged disabled in need of services in New York are nonwhite, the percentage of nonwhite service providers within [New York's VR] is less than one-tenth of one percent of the total number of VR counselors. To wit, New York State is faced with a significant gap in its ratio of nonwhite potential clients to nonwhite service providers" (p. 40).

"Lessons-Learned" Regarding Participatory Action Research Strategies

Access to current information in a timely manner is essential to any research effort. The PI of this project has more than 15 years of experience in conducting research at the community level, as well as with state level agencies, national level agencies, tribal governments, public schools, and in countries outside of the United States. As regards the success of a research effort, the difference is clear between requesting information that is then readily received, versus that which takes months to obtain or with so many restrictions and qualifications as to make the effort not only excessively tedious, but essentially dictates that research can not be carried out under a given time frame.

While public agencies involved in this project were participants, and formally agreed to support the project, delays in producing requested information, or failure to produce requested information, seriously handicapped the research effort. It would appear that the existent bureaucratic structures of the public agencies involved in this research do not serve to produce timely information regarding their service delivery unless personal relationships are in place to provide an entrée to the data. Further, personal energy on the part of the investigators is required to maintain and nourish those relationships throughout the course of research--otherwise, phone calls may not be returned, interviews with key informants not scheduled, and case studies not provided by front-line personnel.

Project Action Outcomes

While difficulties in obtaining timely data, both quantitative and qualitative, were encountered by the research team, positive action outcomes have occurred as a result of this project. As stated earlier, Bruyère (1993) noted that PAR calls for outcomes useful to the community; specifically, she has written that outcomes of research should include "changes in the communities, service delivery systems, and lives of individuals with disabilities being studied" (p. 67). Following the completion of this research project, steps were taken to initiate action outcomes. For example, a two-day training symposium was held on November 9-10, 1995 in Syracuse, New York. Hosted by Cornell University, School of Industrial and Labor Relations, and conducted in collaboration with the AIRRTC, the workshop provided extensive information to representatives from several of the New York State

Indian nations, VR, and other health and human service providers in New York State. Topics included supported employment, use of independent living services, development of and funding for affirmative industries, and effective use of work incentives in the Social Security Insurance system (see Appendix E).

A part of this two-day symposium was devoted to the formal dissemination of the results of the VESID and OMH quantitative data. Symposium participants were provided with an earlier version of this *Final Report*, entitled, *Interim Working Report*, and asked to comment. The low numbers of individuals applying for VR services and sustained in services was discussed; state agency representatives indicated that they felt the data was probably not accurate because regional offices are often not consistent in recording data on ethnicity. In addition, unless the intake worker for the VR agency inquiries about ethnicity, ethnicity may be designated as Caucasian rather than American Indian. Another conference participant indicated that because the eligibility process for such agencies as VR can take significant time for final approval, applicants from indigenous cultures such as the American Indians may become frustrated and refuse to go back. This is one possible explanation for the loss of a percentage of applicants to continue on in services. Another explanation that was offered was that people may apply for services without understanding the true nature of the service and when that is explained to them, they refuse service because this is not the appropriate service for them.

Further discussion on the delivery of VR services to American Indians in New York State also indicated that since 1991, the most recent year for which data were available for analysis, significant reform has occurred in the state agency which may contribute to enhanced outreach and effectiveness of

VR services to American Indians. Counseling staff indicated that since VR reform efforts, the agency has tried to address a number of the issues that were reflected in this and earlier reports about the effectiveness of services to American Indians, with greater recognition of the blocks to service access which have existed for a number of years. Another counselor indicated that when such an assessment of the effectiveness of intervention is made, that it is important not just to count 26 closures (persons successfully placed in employment), but to look at the array of services that have been provided to the target population under study. It may be that the outcomes were not successful placements as determined by the VR system, but that a number of significant services had been provided to the individual, resulting in a heightened quality of life.

Other discussions that occurred over the course of the two-day symposium reflected concerns from American Indian representatives that the difficulty in accessing VR services is not from any dearth of need for services by the American Indian population, but that it is in the approach through which the services are being provided. A segment of attendees felt strongly that for services to be effective, they must be provided in the environment that the American Indian would be comfortable in, such as in local communities or on reservations. This led to a discussion about the possibility of application for a grant from the Rehabilitation Services Administration (RSA) to provide on-reservation vocational rehabilitation services in New York State. Some discussion ensued about the possibility of a coalition across Six Nations to do this collaboratively. Northern Arizona University committed to distributing copies of the 1996 RSA grant application when it became available. Cornell University agreed to pursue the possibility of pulling together representatives to establish a coalition for the writing of such a proposal in the Spring of 1996, should representatives of the leadership of the Six Nations feel that this would be desirable and useful support for their long-range needs in the area of VR for persons with disabilities [A grant-writing workshop sponsored by Cornell University in collaboration with the AIRRTC, "Section 130 Vocational Rehabilitation Program Development," was held June 13 -14, 1996 in Syracuse, New York.]

Other culture-specific recommendations that occurred as a result of the November 1995 training were that non-Native service providers must first learn the culture of indigenous peoples and ask them what they want or need and how they want these services delivered, to be effective in their interventions. It was suggested that there is a need for cultural-sensitivity training for non-American Indians who are in the service delivery system. It was also suggested that it would be beneficial to have more American Indians trained as service providers, such as job coaches, that could go into local communities and on reservations to provide these services in a manner that would be culturally appropriate. Some of the other cultural differences that impact the effectiveness of VR services that were discussed were the concepts of disability and of community. Specifically, American Indian attendees pointed out that some disabilities, including mental illness, are not discussed openly by American Indians with their friends or families; this can make it difficult to seek out support or to get data on actual incidence rates for such illnesses. In addition, it was pointed out by American Indian attendees that the American Indian culture is a different one in terms of priorities, in that community can be a higher priority than employment. For example, if employment is not readily available on the reservation or in the local community, a person may prefer not working or marginal employment opportunities rather than seeking employment away from their primary community.

The following are anecdotal comments and feedback received by Cornell University staff from workshop participants subsequent to the November 1995 symposium:

- "This was the most useful workshop I have ever attended--gained lots of new and useful information. We now have additional resources we did not previously have, and will definitely follow up with some of these contact people."
- "This workshop was better and more than I anticipated--it wasn't just talk about what needs to be done but good information was shared and presented."
- "It was worth it (the time and effort to attend) just to network and share ideas."
- "I wish more people from the Nation could have been here. This (the workshop) is a very good and needed thing--it is the right thing for us to do at this time."
- A recommendation was made to provide some kind of follow-up, either in writing or by the structuring of another meeting or workshop, to pick up on the ideas presented and take them a next step.
- Another suggestion was that the system be streamlined for eligibility determination for VR services, so that individuals do not need to be re-evaluated, resulting in an extended eligibility determination process, and discouraging applicants.
- "Trust must be established first before training, new services, or anything else from the outside (can be effective). To develop this trust,

the 'outsider' needs to visit the Nation, trying to understand the needs, and listen to the people."

- "Service providers from the same Nation sometimes don't communicate or share information or resources with each other. There is a need for better communication and coordination of existing services on the Nations."
- "Information regarding resources and services available for American Indians with disabilities is not getting to the Nations."

CONCLUSIONS AND RECOMMENDATIONS

Given that only a small fraction of American Indians with disabilities may be accessing the public VR program in New York State, and given the lack of specific information which can be obtained from existent data bases, it would seem wise for American Indian advocates to call for a more detailed accounting of where and how American Indians with disabilities are receiving services. As originally proposed, it was anticipated that the statewide reviews of VESID and OMH data, coupled with qualitative data obtained through interviews with key informants, would enable researchers and the PAC to determine whether or not a more intensive needs assessment, for example, in a specific community, was warranted.

Based on the results of this research, as well as from "lessons-learned" in the process of conducting the research, it would appear that community-focused, rather that state-focused needs assessments would prove more beneficial to American Indian communities in New York State. While there is hope that change is underway as a result of previous studies of the public VR system in New York, the statewide data made available for this study indicate that serious problems of access are occurring. It may well take the dedicated and focused energies of local Indian communities to accurately identify local problems of access and local solutions. As stated earlier, dedicated, focused, and intense personal energy is required to carry out a research project. Given the experience of the research team at the **state** level in New York, it was not possible, as this research effort was staffed, to maintain the level of personnel energy required to effectively carry out a participatory research project with a sense of *community*. It would perhaps be more feasible to establish and maintain the necessary personal intensity levels in a given local community.

It would appear that while a comprehensive and integrated service delivery system exists ***on paper*** to meet the needs of American Indians with behavior health diagnoses in New York State, the service system fails, in reality, to reach the service population. As one PAC member commented after reviewing the quantitative results of this research: *"I am not sure why, but the numbers noted seem awfully low given the reported rates of joblessness and poverty among Native American people. . . . [New York State] is a labyrinth of duplication and separation of services significant enough that many individuals [with mental illness] bypass it whenever possible. . . . Our clients are still referred by VESID to sheltered workshops or told them just accept only clerical or other low level work and to be glad for that. . . . These kinds of "take-it-or-leave it" options turn consumers OFF and often cause drop out or refusal of services. They would prefer any other route. On the other hand, the caseloads of VESID workers are staggering and resources very limited. It's almost as though clients have to already be rehabilitated in order to get the money!"*

The barriers that appear to prevent a comprehensive and integrated service delivery system from being fully implemented and accessible to American Indians with behavior health diagnoses include:

1. An attitude expressed by top level administration that cultural difference was not acknowledged. As stated by one leader in the multicultural counseling field, "It is ironic that, in counseling, equal treatment may be discriminatory treatment. And differential treatment is not necessarily preferential. Minority groups want and need equal access and opportunities, which may dictate differential treatment" (Wing Sue, 1992, p. 14).

2. In a related barrier, an apparent lack of understanding by top level administration that VR services should be located on reservations rather than in nearby majority-culture cities and towns. For example, the standards for ethical research published by the American Psychological Association state: "Transportation may be taken for granted by most people, but asking research participants living at subsistence level to report to a laboratory or clinic across the city or in a nearby town for testing may represent an intolerable burden" (from Grisso, et al, 1991, p. 762). Similarly, the administration of public VR agencies must be aware that transportation may be difficult for many American Indian consumers living at subsistence levels in rural areas. According to one recent study (American Indian, 1993), "Indian people have much less access to private vehicles than the general population. Not having a private vehicle creates barriers for people who must make arrangements for friends or relatives to bring them to appointments. Those who cannot find a ride with a relative must rely on public transportation (if available) and experience longer travel times than those who travel by private automobile" (p. 3).

3. Additionally, it may be culturally insensitive to expect that American Indians with disabilities would be comfortable leaving their community to go in search of services in a nearby majority-culture city or town even if transportation were available. As one PAC member commented after reviewing the quantitative results of this research: "*If I were to sum up the whole of everything it would be that there is not a conscious effort to bring these programs to the people, but rather to let the people come to them. . . . If you have a wonderful program and no one can get there, what good is it? Look through the eyes of the person needing the service, not the person providing the service. This is where you will find the answers to all of your questions.*"

Similarly, one key informant commented: *If an Indian person needs services, they need a family advocate or need to know the system. It is not a level playing field if Indian people do not assert themselves and present the same posture as majority culture when applying for services. Argument that "we don't do outreach" doesn't make sense if cultural values preclude person from applying/presenting as agency would expect.* ***Agencies receiving federal funds have a responsibility to serve through outreach.***

Recommendations

These recommendations have been derived not only from the quantitative data presented in the **Results** section of this report, but also from the qualitative data obtained from key informants and comments made by PAC members on earlier versions of this report.

1. Ethical processes, such as responsiveness of federally-supported service systems to the diverse needs of Native peoples, should be

mandated at the federal level for all states receiving public funds to carry out a VR program.

2. Additional services, such as aggressive outreach within American Indian communities, are necessary to ensure an accessible public VR system. In addition to understanding the need for outreach through the documented paucity of American Indian involvement in VR, administrators and counselors might better understand the reluctance of some Indian people to participate through a better historical understanding of American Indian issues as documented in Hauptman (1986), *The Iroquois Struggle for Survival: World War II to Red Power.*
3. Administrations of public VR programs should look to reducing barriers that function to prevent timely access to public data regarding service delivery. Interestingly, a decade ago, Ross and Biggi (1986) called for exactly the same thing, stating that their study of closures of the New York State VR system "revealed the necessity for continuing to organize appropriate, accessible and manipulatable data bases in NYS\OVR so that the equity and efficiency of the vocational rehabilitation service delivery system in New York can be monitored and its service delivery methods tailored to meet the needs of the pluralistic society to be served" (p. 45).
4. A comprehensive census study should be undertaken for all VR cases closed with "refused services" given as the reason for closure. Much could be learned from understanding exactly why American Indians with disabilities refused the services of the public VR agency. For example, were services refused because

they were located too far away from the consumer's residence; because the consumer had no transportation, even if the services were relatively nearby; because the consumer preferred to work with an American Indian counselor; because the consumer found she could obtain work on her own? As one PAC member commented, *"If there is one lesson I have learned over the last 20 years it is that the only way to get the real story about what client's want or need is to ask them."*

5. Public agencies receiving federal dollars to carry out rehabilitation intervention should be required to demonstrate how they are serving American Indians proportionate to the prevalence of disability among American Indians by region [to ensure that rural areas are served] in their state.
6. The administration and line-staff of public agencies receiving federal dollars to carry out rehabilitation intervention should have cultural-competency as one component of their evaluation and promotion criteria.
7. Counselors working with American Indians should be "linked" together via Internet conferences. One key informant reported that VESID provided opportunities for counselors with high numbers of "26 closures" to share their views/experiences of "what works" through both electronic and face-to-face encounters. Similarly, counselors should be provided the opportunity to share "what works" in providing VR services to American Indians. Public VR American Indian consumers should also be provided with opportunities to "chat" and

network electronically if distances prevent face-to-face support group/advocacy meetings.

Any future research regarding the needs of American Indians with behavioral health disorders should be conducted at the local community level, not at the state level. A series of focus group meetings held in 1994 by the Region II Rehabilitation Continuing Education Program, State University of New York at Buffalo illustrate the individual differences which must be addressed in the various Indian communities.

References

[Note: Several documents listed under Existing Documentation are not repeated below; they are available through the Office of Vocational and Educational Services for Individuals with Disabilities (VESID); 1 Commerce Plaza; Albany, NY 12234. An annotated bibliography of all VESID documentation reviewed can be found in Appendix F.]

American Indian Community House, Inc. (1993). *Native American mental health needs assessment*. New York: Author.

Andrews, H., Barker, J., Pittman, J., Mars, L. Struening, E., & LaRocca, N. (1992). National trends in vocational rehabilitation: A comparison of individuals with physical disabilities and individuals with psychiatric disabilities. *Journal of Rehabilitation, 58* (1), 7-16.

Basic Behavioral Science Task Force of the National Advisory Mental Health Council. (1996). Basic behavioral science research for mental health: Sociocultural and environmental processes. *American Psychologist, 51* (7), 722-731.

Brown, M. A., & Basel, D. (1988). Understanding differences between mental health and vocational rehabilitation: A key to increased cooperation. *Psychosocial Rehabilitation Journal, 12* (2), 23-33.

Bruyère, S. M. (1993). Participatory action research: Overview and implications for family members of persons with disabilities. *Journal of Vocational Rehabilitation, 3* (2), 62-68.

Diagnostic and statistical manual of mental disorders, (4th ed.). (1994). Washington, DC: American Psychiatric Association.

Garske, G. G. (1992). Working with people who have severe psychiatric disabilities. *American Rehabilitation, 18*(2), 23-24, 36.

Gloeckler, L. C., Surles, R. C., and Sheldon, T. E. (Eds.). (1993). *Memorandum of understanding between the state education department office of vocational and educational services for individuals with disabilities and the office of mental health.* Interagency Council for Vocational Rehabilitation and Related Services. (April 1993).

Grisso, T., Baldwin, E., Blanck, P. D., Rotheram-Borus, M. J., Schooler, N. R., & Thompson, T. (1991). Standards in research: APA's mechanism for monitoring the challenges. *American Psychologist, 46* (7), 758-766.

International Association of Psychosocial Rehabilitation Services (1986, Fall). *Newsletter*. (Available from IAPSRS, P.O. Box 278, McLean, Virginia, 22101).

Hauptman, L. M. (1986). *The Iroquois struggle for survival: World War II to Red Power*. Syracuse, NY: Syracuse University Press.

Katz, L. J. (1991). Interagency collaboration in the rehabilitation of persons with psychiatric disabilities. *Journal of Vocational Rehabilitation, 1* (3), 45-57.

LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43* (5), 388-397.

Middleton, R., Flowers, C., Zawaiza, T. (1996). Multiculturalism, affirmative action, and Section 21 of the 1992 Rehabilitation Act Amendments: Fact or fiction? *Rehabilitation Counseling Bulletin, 40* (1), 11-30.

Miller, M. & Wittstock, L. W. (1981). *American Indian alcoholism in St. Paul: A needs assessment conducted jointly by the community planning organization and the Juel Fairbanks aftercare residence.* Minneapolis: Center for Urban and Regional Affairs (CURA), University of Minnesota and the Community Planning Organization, Inc. (Available from CURA; 313 Walter Library; 117 Pleasant St., S.E., University of Minnesota; Minneapolis, MN 55455).

The New York State Education Department, Office of Vocational and Educational Services for Individuals with Disabilities. (1993). *1993 amendment to the state plan for vocational rehabilitation and supported employment for federal fiscal years 1992, 1993 and 1994.*

O'Brien, M., Vanek, J., & Welper, L. (1991). *Urban Indian health comparative analysis report.* (Available from the American Indian Health Care Association; 245 East Sixth Street, Suite 499; St. Paul, Minnesota, 55101).

Polcin, D. L. (1992). Issues in the treatment of dual diagnosis clients who have chronic mental illness. *Professional Psychology: Research and Practice, 23*(1), 30-37.

Report to the Governor and Board of Regents of the Interagency Council for Vocational Rehabilitation and Related Services. (1993). (Available from VESID; 1 Commerce Plaza; Albany, NY 12234).

Ross, M. G., & Biggi, I. M. (1986). Critical vocational rehabilitation service delivery issues at referral (02) and closure (08, 26, 28, 30) in serving select disabled persons. In S. Walker, F. Z. Belgrave, A. M. Banner, & R. W. Nicholls (Eds.), *Equal to the challenge: Perspectives, problems, and strategies in the rehabilitation of nonwhite disabled.* Washington, DC: Howard University.

Selikoff, I. J., Hammond, E. C., & Levin, S. M. (undated). *Environmental contaminants and the health of the people of the St. Regis Reserve.* (Available from the Mount Sinai School of Medicine of the City University of New York, Environmental Sciences Laboratory).

Seppa, N. (1996). APA hosts briefing on racism in society. *APA Monitor, 27*(11), 15.

Siris, S. G., & Docherty, J. P. (1990). Psychosocial management of substance abuse in schizophrenia. In M. I. Herz, S. J. Keith, & J. P. Docherty (Eds.), *Handbook of schizophrenia* (Vol. 4, pp. 339-354). New York: Elsevier Science Publishers.

Slaby, A. E. (1991). Dual diagnosis: Fact or fiction. In M. S. Gold & A. E. Slaby (Eds.), *Dual diagnoses in substance abuse* (pp. 3-28). New York: Dekker.

Sobol, T. and Surles, R. (Eds.). (1992). *Memorandum of agreement between the New York state office of mental health and the New York state education department regarding cooperative efforts to improve access and delivery of services to individuals diagnosed with mental illness and their families.*

Statewide comprehensive plan for mental health services, 1993 - 1997. (1992). (Available from New York State Office of Mental Health; 44 Holland Avenue; Albany, NY 12229).

The State Education Department. The University of the State of New York. (1994). *Interim 1994 state plan for the state vocational rehabilitation services program and the state plan supplement for the state supported employment services program.*

The State Education Department. The University of the State of New York. (1994). *Interim 1994 Title VII state plan for independent living.*

The University of the State of New York. The State Education Department. Office of Vocational and Educational Services for Individuals with Disabilities. (1992). *1992 annual update to state plan for independent living services for federal fiscal years 1991, 1992 and 1993.*

The University of the State of New York. The State Education Department. Office of Vocational and Educational Services for Individuals with Disabilities. (1992). *The New York state plan for vocational rehabilitation and supported employment for federal fiscal years 1992, 1993 and 1994.*

U.S. Department of Commerce and Bureau of the Census. (1992). *1990 census of population: Social and economic characteristics, New York.* (Publication No. 1990 CP-1-34). Washington, DC: U.S. Government Printing Office.

U.S. Department of Commerce and Bureau of the Census. (1993). *1990 census of population: Social and economic characteristics, New York.* (Publication No. 1990 CP-2-34). Washington, DC: U.S. Government Printing Office.

Usdane, M. (1993). Supported employment: Working ideals. *American Rehabilitation, 19* (1), 29-32.

Whyte, W. F. (1989). Advancing scientific knowledge through participatory action research. *Sociological Forum, 4* (3), 367-385.

Wing Sue, D. (1992). The challenge of multiculturalism: The road less traveled. *American Counselor, 1* (1), 6-14.

Appendix A

PAC Letters

NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF VOCATIONAL AND EDUCATIONAL SERVICES FOR INDIVIDUALS WITH DISABILITIES
COORDINATOR OF PROGRAM DEVELOPMENT, TECHNICAL ASSISTANCE & SUPPORT SERVICES

May 2, 1994

Dr. Catherine A. Marshall
Director of Research/
Associate Professor
American Indian Rehabilitation
Research & Training Center
Northern Arizona University
P.O. Box 5603
Flagstaff, AZ 86011-5630

Dear Dr. Marshall:

By now you have received the April 15, 1994 letter from Assistant Commissioner Edmund Cortez indicating that William A. Carpenter has been assigned as the VESID Central Office representative to work on this project and to represent VESID on the Advisory Council.

Bill Carpenter is gathering and forwarding the information you requested. Locating and collecting some of the information you requested involves staff from other Units within VESID and the Education Department. Bill is working with those Units to forward that information to you as quickly as possible. The following has already been completed and will be sent to you under separate cover.

1. Copies of the materials you requested that were left in Assistant Commissioner Cortez' office.

2. A summary in hard copy of the work VESID has accomplished regarding American Indians over the past two years. (A disk is not available.)

3. VESID and Education Department policy on releasing information to outside sources requires that the person or agency provide a specific written request for the data and the format in which they would prefer to receive the data. VESID and the Department will then appropriately respond to the request.

BEST COPY AVAILABLE

4. Bill Carpenter is presently working with the VESID Manager of Local Operations to identify staff and/or consumers who would be able to participate in the project as members of the Advisory Committee. When Bill has received the names, he will forward them to you as quickly as possible.

As you read in Assistant Commissioner Cortez' letter, Bill Carpenter is setting up a meeting with Susanne Bruyere, Minerva White, Frank Abrams, Edmund Cortez and myself to begin discussing and moving forward on this project. I look forward to working with you on this project and possibly seeing you in June.

Sincerely,

Debra Colley

Debra A. Colley, Ph.D.

cc: E. Cortez
W. Carpenter

St. Regis Mohawk Tribe
Health Services

Rt. 37, Box 8A
Hogansburg, New York 13655
Tel. 518-358-3141
Fax 518-358-2797

Tribal Chiefs
L. David Jacobs
John S. Loran
Norman J. Tarbell
Health Director
Margaret Terrance

April 21, 1994

Catherine A. Marshall, Ph.D.
Director of Research
Institute for Human Development
Arizona University Affiliated Program
Northern Arizona University
P.O. Box 5630
Flagstaff, Arizona 86011-5630

Dear Dr. Marshall:

I am in receipt of your research proposal to evaluate service delivery to American Indians who require vocational rehabilitation and/or mental health services in New York State. The reports that you included in the package will be useful in our program planning, especially regarding services to the family support systems. Thank you for sharing this information with me.

As you requested, I have given serious thought to serving as a member of your project advisory committee and have decided to join your committee. Our efforts to expand program delivery for mental health services has been hampered by the State of New York's lack of knowledge regarding our community's needs. This report will potentially assist all American Indians within New York State to access services which they so desperately need.

I look forward to meeting you in July to discuss this in more depth.

Sincerely,

Margaret Terrance

Margaret Terrance
Executive Director

c.c. Tribal Administration

The Web
Native Americans at Cornell

Spring 1994

INSIDE THIS ISSUE:

▼***Student Profiles***
Mary Fadden, Tom Ferguson, Natalie Hemlock, Ruth Ramos
▼***Native American Faculty Update***
▼***AIP Director News***
▼***Archaeology Project***

Student Works on Community Issues

*I*n planning her educational goals, Natalie Hemlock, a Ph.D. candidate in Educational Administration, says, "I am always looking for the connection between what I am learning here and how it can help out at home." Raised on the Cattaraugus Reservation, Natalie spent several years working as a library administrator, Headstart director, and a consultant for the Seneca Nation before returning to school at Cornell, where she earned a bachelor's degree in Education in 1988.

> ***"I am always looking for the connection between what I am learning here and how it can help out at home."***

"I had a strong desire for intellectual change," Natalie says of her decision to return to college as an older student. "Choosing the field of education was a natural process. It was connected to all that I had done so far and all that I wanted to accomplish." After completing her master's in Administration, Planning, and Social Policy at Harvard, Natalie returned to Cornell where she expects to finish her Ph.D. in August of 1994.

Being Native American has affected her approach to and perspective on her studies. "Academic institutions tend to focus on the problems of Indian communities, but I focus instead on the possibilities," she says.

▼*Continued on page two*

Professor Sherene Baugher (right) and students from her City and Regional Planning class excavate a two-to-three thousand year-old settlement in Inlet Valley. See photo essay on page six.

Grad Looks for Home-based Solutions

Mary Francis Fadden. Photo by David Lynch-Benjamin

*M*ohawk student Mary Francis Fadden grew up in the urban environment of Buffalo, New York, but her affinity for nature was never in doubt. For one thing, she loved the zoo and spent many days visiting the animals.

"I loved animals right away," Fadden said. "I always knew I would work with animals as a vet and on environmental issues generally." Fadden, who earned a Doctor of Veterinary Medicine degree from Cornell in 1990, is currently finishing a Ph.D. in Ecotoxicology. Her research focused on toxicity problems at the Akwesasne (St. Regis) Reservation, where she hopes to continue to assist the community with its environmental issues.

Fadden points out the many environmental problems in Indian Country:

▼*Continued on page four*

BEST COPY AVAILABLE

Full Circle

The Cornell American Indian Program
Offers Excellence In Education

Colleges:
- *College of Agriculture and Life Sciences*
- *College of Architecture, Art, and Planning*
- *College of Arts and Sciences*
- *College of Engineering*
- *School of Hotel Administration*
- *College of Human Ecology*
- *School of Industrial and Labor Relations*

Graduate Programs:
- *Graduate School's 89 Fields of Study*
- *College of Engineering*
- *School of Industrial and Labor Relations*
- *Law School*
- *Johnson School of Management*
- *College of Veterinary Medicine*
- *Cornell Graduate School of Medical Sciences*
- *Cornell University Medical College*

The Common Link-The Native American Heritage
Different Tribes, Different Nations • A Shared History, A Shared Experience
The Cornell American Indian Program

AMERICAN INDIAN PROGRAM
300 Caldwell Hall
Cornell University
Ithaca, New York 14853-2602
Telephone: (607) 255-6587
FAX: (607) 255-6246

If you would like further information, please complete this form and mail to the above address

Name ____________
Address ____________
____
Telephone (___) ____________
Tribal Affiliation ____________
Enrolled Member? ____________
High School Name ____________
High School Graduation (year) ____________
College Transfer/Graduate Prospect? ____________
Current College ____________
Major ____________
Two or Four Year Program? ____________
Interested in Cornell Transfer Program? ____________
Interested in Graduate Programs? ____________
If interested in Cornell University as a Freshman, Transfer Prospect, or Graduate Student, I will enroll
Fall, 19___ Spring, 19___ Summer, 19___

CORNELL

English Professor Coordinates Native Culture Conference

This semester, assistant professor of English, Kate Shanley coordinated "Cultural Production/Cultural Copyright," a conference, that took place from March 31 to April 2, 1994. Conference panelists explored cultural sovereignty in relation to language, cultural symbols, artifacts, customs and the Native American struggle to remain culturally distinct. Sponsored by the A.D. White Center for the Humanities, with additional support from the AIP, Cornell Council for the Arts (NEA Visual Arts Grant), Department of English, Minority Finance Commission, Native American Students at Cornell, Rural Sociology and the Goldsen Fund: Images and Society, "Cultural Production/Cultural Copyright" featured readings, presentations and panel discussions with Betty Louise Bell, Robbie Ferron, and Ofelia Zepeda.

In her presentation, "Pocahantas: Recovery Within the Circle of Silence," Dr. Bell shared insights from her research on Pocahantas as an American icon, and discussed the place of native women's lives and stories within literature. Ms. Ferron, co-director of the Affirmative Action/Equal Opportunity office at the University of Washington, and a lawyer who frequently lectures on the threat of Fetal Alcohol Syndrome, gave a talk entitled "Cultural (Re)production: American Indian Women's Rights Under Tribal and Federal Law." In it, she stressed the importance of establishing healthcare policies that both protect the rights of individual women and ensure the continuance of Native nations. In "Creating and Shaping a Written Tribal Literature," Dr. Zepeda spoke of her work to create a written literature in the language of the Tohono O'odam (Papago). Currently, very little literature (only a few missionary tools and a small collection of stories) exists to reflect the worldview of the people. The written materials will be used to teach the language to college students and to develop a curriculum for grade school and high school education.

Before coming to Cornell in 1992, Kate Shanley (Assiniboine from Fort Peck, Montana) completed both her master's and her Ph.D. at the University of Michigan, Ann Arbor. She taught at the University of Washington in Seattle from 1985 to 1992. At Cornell, she is active within the AIP, serving this semester as a faculty fellow for the Akwe:kon residence house, and organizing other events such as a reading with Hopi artist and poet Ramson Lomatewama this April. ▲

Disability Project Organizers Request Student Assistance

A research project entitled, "An Examination of the Vocational Rehabilitation Needs of American Indians with Behavioral Health Diagnoses in New York State," is being conducted through the American Indian Rehabilitation Research and Training Center (AIRRTC) located at Northern Arizona University, and in collaboration with The Program on Employment and Disability in the School of Industrial and Labor Relations at Cornell. The purpose of the research project is to examine the current level of vocational rehabilitation and mental health services being provided in New York State to American Indians with behavioral health diagnoses, including those with dual diagnoses involving substance abuse.

The research team, Dr. Catherine Marshall, Director of Research at the AIRRTC; Dr. Susanne Bruyäre, Director, Program on Employment and Disability; Dr. David Shern, Director, Evaluation and Services Research, New York State Office of Mental Health; and Dr. Lois Jircitano, will assess whether or not additional services are needed to ensure successful vocational rehabilitation outcomes, and will identify opportunities to establish and/or strengthen collaborative programs between the Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the New York Office of Mental Health (OMH).

American Indian students or faculty who would like more information about the project or who may be interested in serving on the project advisory committee are urged to contact either Dr. Bruyäre at 255-7727 and BRUYERE@QMRELAY.MAIL.CORNELL.EDU or Dr. Marshall at 1-800-553-0714 and MARSHALL@NAUVAX.UCC.NAU. EDU. ▲

BEST COPY AVAILABLE

Appendix B

Disability Status of American Indian Civilian Non-institutionalized Persons in Non-reservation Land Areas of New York State in 1990

Disability Status of American Indian Civilian Non-institutionalized Persons in Non-reservation Land Areas of New York State in 1990.

State Urban and Rural Inside and Outside Metropolitan Area	Urban and Rural						Inside and Outside Metropolitan Areas				
	Urban				Rural		Inside Metropolitan Area			Outside Metropolitan Area	
		Inside Urbanized Area									
	Total	Central Place	Urban Fringe	Outside Urbanized Area	Total	Farm	Total	In Central City	Not in Central City	Total	Rural
Persons 16 to 64 Years	**30,026**	**20,593**	**6,729**	**2,704**	**8,879**	**114**	**32,900**	**20,574**	**12,326**	**6,005**	**4,312**
with a mobility or self-care limitation	3,243	2,673	376	194	580	2	3,404	2,649	755	419	293
with a mobility limitation	1,563	1,169	255	139	346	2	1,635	1,156	479	274	191
In labor force	402	327	63	12	48	2	423	327	96	27	21
with a self-care limitation	2,557	2,208	247	102	377	-	2,709	2,184	525	225	167
with a work disability	4,144	2,681	995	468	1,303	21	4,531	2,672	1,859	916	614
In labor force	1,535	938	404	193	509	16	1,701	934	767	343	213
Prevented from working	2,213	1,484	475	254	668	2	2,400	1,479	921	481	324
No work disability	25,882	17,912	5,734	2,236	7,576	93	28,369	17,902	10,467	5,089	3,698
In labor force	19,494	13,090	4,594	1,810	5,661	74	21,468	13,086	8,382	3,687	2,580

Table Continues

State Urban and Rural Inside and Outside Metropolitan Area	Urban and Rural						Inside and Outside Metropolitan Areas				
	Urban				Rural		Inside Metropolitan Area			Outside Metropolitan Area	
		Inside Urbanized Area									
	Total	Central Place	Urban Fringe	Outside Urbanized Area	Total	Farm	Total	In Central City	Not in Central City	Total	Rural
Persons 65 to 74 years	**1,735**	**1,156**	**428**	**151**	**679**	**12**	**1,934**	**1,156**	**778**	**480**	**375**
with a mobility or self-care limitation	491	366	102	23	124	2	518	366	152	97	77
with a mobility limitation	347	251	75	21	107	-	367	251	116	87	69
with a mobility limitation	373	278	74	21	79	2	375	278	97	77	59
Persons 75 years and over	**1,068**	**789**	**219**	**60**	**343**	**4**	**1,167**	**783**	**384**	**244**	**204**
with a mobility or self-care limitation	482	398	71	13	115	-	515	398	117	82	69
with a mobility limitation	326	261	58	7	106	-	363	261	102	69	62
with a self-care limitation	341	294	34	13	58	-	346	294	52	53	40

Appendix C

Frequencies of Persons Ages 15 to 64 Living on Reservation and Trust Land in New York State in 1990, by Reservation

Frequencies of Persons Ages 15 to 64 Living on Reservation and Trust Land in New York State in 1990, by Reservation.
(N=6,331)

American Indian Area	American Indian Reservation and Trust Land								
	All Areas	Allegany Reserv., NY	Cattaraugus Reserv., NY	Oneida (East) Reserv., NY	Poospatuck Reserv., NY (state)	St. Regis Mohawk Reserv. NY	Shinnecock Reserv., NY (state)	Tonawanda Reserv., NY	Tuscarora Reserv., NY
All persons	6,331	1,068	1,979	41	164	1,923	355	448	353

Appendix D

Disability Status of American Indian Civilian Non-institutionalized Persons on American Indian Reservations and Trust Land in New York State in 1990

Disability Status of American Indian Civilian Non-institutionalized Persons on American Indian Reservations and Trust Land in New York State in 1990.

American Indian Area	All Areas	Allegany Reserv., NY	Cattaraugus Reserv., NY	Oneida (East) Reserv., NY	Poospatuck Reserv., NY (state)	St. Regis Mohawk Reserv. NY	Shinnecock Reserv., NY (state)	Tonawanda Reserv., NY	Tuscarora Reserv., NY
Persons 16 to 64 Years	**3,732**	**622**	**1,148**	**22**	**109**	**1,184**	**205**	**264**	**178**
with a mobility or self-care limitation	187	34	62	-	8	61	2	10	10
with a mobility limitation	81	16	34	-	8	11	2	10	-
In labor force	5	3	-	-	-	-	2	-	-
with a self-care limitation	145	25	53	-	-	55	2	-	10
with a work disability	412	67	179	-	16	70	14	39	27
In labor force	143	24	68	-	8	39	4	-	-
Prevented from working	235	40	94	-	8	31	10	33	19
No work disability	3,320	555	969	22	93	1,114	191	225	151
In labor force	2,325	439	723	12	62	658	149	145	137

Table Continues

American Indian Area	All Areas	Allegany Reserv., NY	Cattaraugus Reserv., NY	Oneida (East) Reserv., NY	Poospatuck Reserv., NY (state)	St. Regis Mohawk Reserv. NY	Shinnecock Reserv., NY (state)	Tonawanda Reserv., NY	Tuscarora Reserv., NY
Persons 65 to 74 years	**419**	**53**	**112**	-	**7**	**118**	**41**	**38**	**50**
with a mobility or self-care limitation	67	12	20	-	-	17	4	4	10
with a mobility limitation	61	10	17	-	-	17	3	4	10
with a mobility limitation	43	6	18	-	-	14	1	4	-
Persons 75 years and over	**201**	**35**	**69**	-	-	**58**	**16**	**23**	-
with a mobility or self-care limitation	61	12	24	-	-	8	3	14	-
with a mobility limitation	54	10	19	-	-	8	3	14	-
with a self-care limitation	32	12	15	-	-	-	-	5	-

Appendix E

Rehabilitation of American Indians with Behavioral Health Disorders in New York State: Workshop Agenda

Rehabilitation of American Indians with Behavioral Health Disorders in New York State

November 9 — 10, 1995
Goldstein Auditorium
Syracuse University
Syracuse, New York

Sponsored by

American Indian Rehabilitation Research and Training Center
Northern Arizonia University, Flagstaff, Arizona

Program on Employment and Disability
Cornell University, Ithaca, New York

Counseling and Human Services
Syracuse University School of Education

New York State Office of Mental Health

New York Office of Vocational and
Educational Services for Individuals with Disabilities

Central New York School Study Council

Rehabilitation of American Indians with Behavioral Health Disorders in New York State

November 9 - 10, 1995
Syracuse, New York

Agenda

November 9

8:30	Opening Remarks *Paul Pedersen, Ph.D.*
9:00	Vocational Rehabilitation Needs of American Indians with Behavioral Health Disorders in New York State *Catherine Marshall, Ph.D. and Susanne Bruyère, Ph.D.*
10:30	*Break*
10:45	Issues in the Rehabilitation of American Indians *Timothy C. Thomason, Ed.D.*
11:30	*Lunch* (on your own)
1:00	Establishing Linkages with Vocational Rehabilitation and Mental Health Service Providers *William Carpenter and (? yet to be announced)*
2:30	*Break*
2:45	Supported Employment: Programs and Practices *Melissa Weiss*
4:00	Reception *(sponsored by CNY School Study Council and Counseling and Human Services, Syracuse University)*

The following videos will be shown immediately after the reception - please feel free to join us for any or all of the presentations. Facilitator: Catherine Marshall, Ph.D.

5:30	Winds of Change — About how the Onondaga people of NY work to preserve their clan, and what happens when youth leave the reservation for school and work.
6:30	Acts of Defiance — Coverage of the Mohawk bridge blockade at Kahnawake and the protest at Kanehsatake over tribal lands.
8:15	Kaneshsatake: 270 Years of Resistance — A different version of the protest over tribal lands at Kanehsatake.

Agenda, Continued

November 10

8:30	Affirmative Businesses: Values Based Business Development *Gary Shaheen and Carol Bianco and Fred Powers*
10:00	*Break*
10:20	Affirmative Business: Values (continued) and Generating Resources *Gary Shaheen, Carol Bianco and Fred Powers*
11:40	Affirmative Businesses: Questions and Discussion
12:00	*Lunch* (on your own)
1:30	Rehabilitation and Mental Health Services for American Indians in NYS Panel Discussion *Facilitator - Tim Thomason* *Panel - Service Providers from Nations in New York State*
3:00	Summary; Next Steps; Workshop Evaluation

Appendix F

Literature from the Office of Vocational and Educational Services for Individuals with Disabilities

Literature from the Office of Vocational and Educational Services for Individuals with Disabilities

1) VESID Comprehensive Action Plan for Reform. The University of the State of New York. The State Education Department.

This Comprehensive Action Plan summarizes VESID's Plan to reform its system of service delivery. This plan describes activities which began in 1989, under the first phase of reform, which improved the ease with which persons with disabilities access vocational rehabilitation services. The plan then details activities planned for the second phase of reform to further improve the way in which services are provided. In addition to the plan itself this document includes the compelling vision upon which the reform effort is based, related policy changes resulting from the newly amended Rehabilitation Act of 1992, the impact of Chapter 515 of New York State Law and the policy directions of the State Interagency Council for Vocational Rehabilitation and related Services, a description of the process by which recommendations for change were developed, the modifications made to recommendations based on public input, and next steps.

2) 1992 Annual Update to State Plan for Independent Living Services for Federal Fiscal Years 1991, 1992, and 1993. The State Education Department. The University of the State of New York. The Office of Vocational and Educational Services for Individuals with Disabilities.

The State Plan for Independent Living Services is the legal document which allows the Office of Vocational and Educational Services for Individuals with Disabilities (VESID) to qualify for and receive Federal funds for independent living services for persons with disabilities. This 1992 Annual Update consists of a set of attachments which describe VESID's policies related to program implementation. The Annual Update also includes assurances required by the Federal Rehabilitation Act of 1973 and its subsequent amendments, which seek to assure that all state vocational rehabilitation programs will be administered in a consistent manner. In addition, this Annual Update allows VESID to highlight its mission to provide independent living services to persons with disabilities.

3) Interim 1994 Title VII State Plan for Independent Living. The State Education Department. The University of the State of New York.

In accordance with the provisions of Title VII chapter 1 of the 1992 Amendments to the Rehabilitation Act of 1973 the Office of Vocational and

Educational Services for Individuals with Disabilities (VESID) must submit the Interim 1994 Title VII State Plan for Independent Living. This Interim State plan includes required attachments which provide information on how the State of New York will meet the new requirements of the Rehabilitation Act Amendments of 1992. This Interim 1994 Title VII Plan for Independent Living is divided into the following sections:

Section I:	A description of the Public Comment Process and summary of Public Comments.
Section II:	Attachments Required Under the Rehabilitation Act Amendments of 1992; and
Section III:	Preprint for the Interim 1994 Title VII State Plan for Independent Living.

Attached to this document is a memorandum from Lawrence Gloeckler to the Honorable Members of the Board of Regents Committee on Vocational and Educational Services for Individuals with Disabilities which announces the approval of the Interim 1994 Title VII State Plan for Independent Living.

4) The New York State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993, and 1994. The University of the State of New York. The State Education Department. Office of Vocational and Educational Services for Individuals with Disabilities.

The New York State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993, and 1994 provides the framework for the Office of Vocational and Educational Services for Individuals with Disabilities (VESID) to promote full opportunities for all individuals with disabilities in both the workplace and the community. It is a legal compact which describes the nature, scope, and conditions of the State's program and ensures that program administration will conform to the Rehabilitation Act and Federal regulations. The publication of this plan allows VESID to comply with the initiatives required by the Rehabilitation Act and its amendments and serves as a basis for continuing Federal funds. In accordance with the Rehabilitation Act of 1973 (Public Law 93-112) as amended by the 1986 Amendments (Public Law 99-506), this document consists of :

1) Required State assurances;

2) Attachments for Title I and Title VI; and

3) Goals and priorities for fiscal years 1992 to 1994 for vocational rehabilitation and supported employment.

5) 1993 Amendment to the State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal years 1992, 1993, and 1994. The New York State Education Department. Office of Vocational and Educational Services for Individuals with Disabilities.

Throughout the year of 1991 the Office of Vocational and Educational Services for Individuals with Disabilities developed the State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993, and 1994. See the description above on number 4. In accordance with the Rehabilitation Act of 1973 (Public Law 93-112) as amended by the Rehabilitation Act Amendments of 1986 (Public Law 99-506), the designated rehabilitation agency must submit an amendment to the approved State Plan Each year. The 1993 Amendment to the State Plan for Vocational Rehabilitation and Supported Employment for Federal Fiscal Years 1992, 1993, and 1994 consists of annual updates to the following attachments which are required by the Rehabilitation Services Administration.

Title I Attachments:

2.5A:	Summary of Public Comments and the Designated State Unit's Response to the Comments.
9.1(c)A:	Changes in Policy Resulting From Statewide Studies and Annual Program Evaluation.
9.4A:	Methods to Expand and Improve Services to Individuals with the Most Severe Disabilities.
10.6(b)A:	Designated State Unit's Plans, Policies and Methods Relating to Transitioning.

Title VI, Part C Attachments:

1.7A:	Description of Quality, Scope and Extent of Supported Employment Services.
1.8A:	State's Goals and Plans Regarding Distribution of Funds Received under Title VI, Part C.

6) ACCESS: Plan for Ensuring Access for Individuals with Disabilities to All New York State Education Department Programs and Services. The University of the State of New York. The State Education Department Programs and Services. Albany, New York. August, 1991.

This document/plan represents a starting point for ensuring that all Department programs and services are accessible to individuals with disabilities and outlines a process by which the Department will monitor the implementation of the Plan. This Plan also outlines the commitment of the State Education Department to ensure equal access to all Department programs, services, and employment opportunities to individuals with disabilities.

7) Annual Report on ACCESS: Annual Report on the Plan for Ensuring Access for Individuals with Disabilities to all New York State Education Department Programs and Services. The University of the State of New York. The State Education Department. 1992.

This report provides an overview of activities that offices within the State Education Department undertook during the last year to promote the accessibility of people with disabilities to department programs and services which are available to the public at large. It also summarizes the accomplishments which have occurred as a result of the collaborative working relationships formed among various Department offices through the Intra Agency Council and the emerging issues which will be addressed in the next year's work plans.

8) Racial/Ethnic Distribution of Public School Students and Staff: New York State 1992-93. The University of the State of New York. The State Education Department Instruction and Program Development. Albany, New York.

This document is a list of sixteen tables that outline the following:

Table 1) Racial/Ethnic Distribution of Public School Students, 1992-93;

Table 2) Distribution of black and Hispanic Public School Students, 1992-93;

Table 3) Percent Distribution of Public School Students by Racial/Ethnic Origin, 1989-90 through 1992-93;

Table 4) Number of Schools and Number and Percent of Minority Students in Schools of Differing Racial Composition, 1992-93;

Table 5) Number of Schools and Number and Percent of Black Students in Schools of Differing Racial Composition, 1992-93;

Table 6) Number of Schools and Number and Percent of Hispanic Students in Schools of Differing Racial Composition, 1992-93;

Table 7) Percent Distribution of Public School Professional Staff by Racial/Ethnic Origin, 1992-93;

Table 8) Percent Distribution of Public School Professional Staff by Racial/Ethnic Origin, 1989-90 through 1992-93;

Table 9) Percent Distribution of Public School Classroom Teachers by Racial/Ethnic Origin, 1992-93;

Table 10) Percent Distribution of Public School Classroom Teachers by Racial/Ethnic Origin, 1989-90 through 1992-93;

Table 11) Percent Distribution of Public School Students by Racial/Ethnic Origin (Listed by School District Within County), 1992-93;

Table 12) Percent Distribution of Full-time BOCES Students by Racial/Ethnic Origin (Listed by BOCES), 1992-93;

Table 13) Percent Distribution of Public School Professional Staff by Racial/Ethnic Origin(Listed by School District Within County), 1992-93;

Table 14) Percent Distribution of BOCES Professional Staff by Racial/Ethnic Origin (Listed by BOCES), 1992-93;

Table 15) Percent Distribution of Public School Classroom Teachers by Racial/Ethnic Origin (Listed by School District Within County), 1992-93; and

Table 16) Percent Distribution of BOCES Classroom Teachers by Racial/Ethnic Origin (Listed by BOCES), 1992-93.

9) Opportunity & Independence, Meeting the Needs of New Yorkers with Disabilities: The Final Report of the Regents Select Commission on Disability. July, 1993. University of the State of New York and the State Education Department.

This document is made up of two parts. The first part is the Final Report of the Regents Select Commission on Disability which contains eight findings that reflect the status of disability programs and policy in New York State. These findings are:

1) The need for coordination and monitoring of service delivery;

2) The need for better awareness of and access to services, and for changes in public attitudes;

3) Some change is taking place;

4) Expectations must be high and must be conditioned by fiscal reality;

5) Services should be defined by the needs of individuals with disabilities, not by service providers or funding agencies;

6) State government must measure its efforts against a rigorous standard of outcomes;

7) The need for better data and commonly understood definitions of needs; and

8) Inclusion in the education system and the workforce, and participation in society must be major goals of a new disability policy.

In addition to these eight findings the "Final report" lists four policy goals that revolve around participation, access, focus, and leadership by example. Part two of this document is titled "Background Research" and is comprised of several chapters that cover social services, advocacy and medical issues; legal and economic issues; education issues; media and people with disabilities; statistics and demographics; technology issues; and vocational and employment issues.

10) The State of New York Integrated Employment: Implementation Plan Chapter 515, the Laws of 1992. New York State Education Department, Office of Vocational and Educational Services for Individuals with Disabilities, new York State Office of Mental Health, New York State Department of Social Services, Commission for the Blind and Visually Handicapped, and new York State Office of mental Retardation and Developmental Disabilities.

This document details the accomplishments and progress that has been achieved through interagency cooperation in the delivery of community based employment services and supports for people with disabilities. It also sets forth the vision for developing employment opportunities for those individuals who have not yet had access to integrated employment. To address this substantial need and consumer demand for integrated employment, the State agencies participating in the development of this implementation plan have propose four major strategy themes:

1) Consumer empowerment and informed choice;

2) Employment opportunities and employer partnerships;

3) Coordination and delivery of supports; and

4) Management and administration of the system.

The intended outcome of this plan is to continue to create the type of service delivery environment where business and industry can provide employment opportunities in a true partnership with the provider community and state agencies.

11) 1990 Annual Report: Office of Vocational and Educational Services for Individuals with Disabilities. The University of the State of New York. The State Education Department.

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) within the State Education Department (SED) is charged with providing and coordinating programs for persons with disabilities. This document highlights the role that VESID had in 1990 in developing and coordinating appropriate services so that people with disabilities could lead self-sufficient, self-directed lives to the maximum extent possible. Specifically, this document discusses VESID's philosophy of service, management principles, program priorities and 1990 accomplishments. In addition, a profile of the people served by VESID in 1990 is included.

12) 1991 Annual Report: Office of Vocational and Educational Services for Individuals with Disabilities. The University of the State of new York. The State Education Department.

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) within the State Education Department (SED) is charged with providing and coordinating programs for persons with disabilities. This document highlights the role that VESID had in 1991 in developing and coordinating appropriate services so that people with disabilities could lead self-sufficient, self-directed lives to the maximum extent possible. Specifically, this document discusses VESID's philosophy of service, management principles, program priorities and 1991 accomplishments. In addition, a profile of the people served by VESID in 1991 is included.

13) 1993 Annual Report: Office of Vocational and Educational Services for Individuals with Disabilities. The University of the State of new York. The State Education Department.

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) within the State Education Department (SED) is charged with providing and coordinating programs for persons with disabilities. This document highlights the role that VESID had in 1993 in developing and coordinating appropriate services so that people with disabilities could lead self-sufficient, self-directed lives to the maximum extent possible. Specifically, this document discusses VESID's philosophy of service, management principles, program priorities and 1993 accomplishments. In addition, a profile of the people served by VESID in 1993 is included. Also included are descriptions of VESID's district offices.

14) Report to the Governor and Board of Regents of the Interagency Council for Vocational Rehabilitation and Related Services. April 1993.

This report describes the status of activities undertaken by the State Interagency Council for Vocational Rehabilitation and Related Services, including the Council's efforts to increase employment opportunities for persons with disabilities through an improved local service delivery system and linkages to business, industry and labor; significant legislative changes that resulted from council activities; composition and structure of the

Council; relevant interagency actions taken; and the anticipated focus of the Council over the next year. The report also includes an executive summary.

15) Momentum. Fall 1992. The University of the State of New York. The State Education Department. Office of Vocational and Educational Services for individuals with Disabilities.

Momentum is a publication that is put out by the Vocational and Educational Services for Individuals with Disabilities. This issue reflects the theme of consumerism as it relates to self determination, independent living, service delivery, and employment among people with disabilities.

16) VESID. The University of the State of New York. The State Education Department. Office of Vocational and Educational Services for individuals with Disabilities. Albany, New York.

This booklet contains an Application for Services from VESID and it provides information about programs that help people with disabilities lead productive, independent lives.

17) New York State Plan for Education of Students with Disabilities: 1993 - 1995. The University of the State of New York. The State Education Department. Office for Special Education Services. Albany, New York.

This document provides information on how the system established by the New York State Education Department for the provision of Special education programs and services in the least restrictive environment is consistent with requirements included in the Individuals with Disabilities Education Act (IDEA) and Part 300 of the Code of Federal Regulations. In addition to being a document which demonstrates compliance with Federal requirements, the State Plan describes the planning and program initiatives to be undertaken at the State level regarding the provision of special education programs and services during the next State Plan cycle (1993-1995).

18) Memorandum-"Joint Agreement of the Provision of Transition Services." From Lawrence C. Gloeckler and Arthur L Walton. October 30, 1992.

This memorandum contains the Joint Agreement between the Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the Office of Elementary, Middle and Secondary Education (EMS) on the provision of transition services for youth with disabilities. VESID and EMS agree to collaborate, and wherever possible, integrate resources to enable students with disabilities to successfully transition from school to adult life and fully participate in their community. The collaborative efforts of the two Offices will address an array of issues and initiatives, including assisting students with disabilities and their families in accessing appropriate services, enhancing integration of transition services and programs within the schools and ensuring integrated adult opportunities.

19) Implementation Plan for the Equal Opportunity for Women Policy Paper.

This compilation of documents includes four memorandums that suggest changes to the Implementation Plan for the Equal Opportunity for Women Policy Paper and a draft of the Implementation Plan. This plan includes action strategies for ending gender bias; action strategies for improving opportunities for the education of women and girls in schools, higher education, and cultural institutions; and action strategies for improving career opportunities in education, cultural institutions and professions.

20) Regents Committee on Vocational and Educational Services for Individuals with Disabilities Flow Sheet.

This flow sheet lists five objectives, each of which is followed by several sub-objectives. There are yearly goals set up for each sub-objective for the years between 1991 and 1996. The five objectives fall under the headings of Interagency Activities, Access to Services, Linkages, Improving Consumer Services, and Research.

21) Memorandum - "Highlights of VESID Budget Request for SFY 94/95" from Lawrence C. Gloeckler to Commissioner Sobol. October 15, 1993. ***and*** Testimony of Thomas Sobol, President of the University of the State of New York and Commissioner of Education, Before the Division of Budget. Wednesday, October 20, 1993, Room 124, State Capitol, Albany, New York.

These two documents appear together in a single packet. The memorandum from Lawrence C. Gloeckler to Commissioner Sobol summarizes the VESID budget in preparation for Commissioner Sobol's Testimony before the Division of Budget. in his Testimony before the Division of Budget Commissioner Sobol discussed the work and needs of the education community in the State of New York. By "education community" he is meaning elementary and secondary schools, colleges and universities, library users, museum goers, persons with disabilities who receive vocational and educational services and many other citizens served by educational institutions in the state of New York.

22) Strategic Plan for Developing and Expanding Vocational Rehabilitation Services in New York State for Federal Fiscal Years 1994, 1995, and 1996. Effective October 1, 1993. New York State Education Department.

Office of Vocational and Educational Services for Individuals with Disabilities. August 1, 1993.

The 1992 Amendments to the Rehabilitation Act of 1973 require that each state prepare and submit to the Rehabilitation Services Administration Commissioner "a statewide strategic plan for developing and using innovative approaches for achieving long-term success in expanding and improving vocational rehabilitation services, including supported employment services." This document is intended to fulfill that requirement. It outlines the mission and philosophy of the vocational rehabilitation program administered by VESID; the specific goals and objectives for expanding and improving the vocational rehabilitation system; methods for accomplishing the objectives; and implementing and evaluating the plan.

23) Bill Packet.

This packet contains three memoranda in support of three bills that were written to amend current laws. In addition to the memoranda there are copies of the actual bills with the suggested corrections. The memoranda are:

A: Memorandum in Support of "An Act to Amend the Educational Law, In Relation to Establishing Programs Providing Training and Technical Assistance for Employers of Individuals with Disabilities and making an Appropriation Therefor "The purpose of this bill was to provide employers in targeted businesses and industries with technical assistance and training services, resulting in increased employment opportunities for individuals with disabilities.

B: Memorandum in Support of "An Act to Amend the Education Law and the State Finance Law, in Relation to the Lease-Purchase or Rental of a Vehicle on Behalf of Certain Individuals with Disabilities" The purpose of this bill is to facilitate the provision of cost effective t transportation services to certain individuals with disabilities who are consumers of the Office of Vocational and Educational Services for Individuals with Disabilities.

C: Memorandum in Support of "An Act to Amend the Tax Law in Relation to Authorizing a Tax Credit for Employing Individuals with Disabilities and Providing for a Method of Certification of Disability for Such Workers." The purpose of this bill is to promote the hiring of workers with disabilities and to conform the New York State Tax Law to the United States Internal Revenue Code, by amending the New York State Tax Law to establish a mechanism to certify the eligibility of workers with disabilities and to provide business tax credits to employers who hire such certified workers.

24) "Memorandum - Priority 'C' List." From Marge Tierney to Lawrence Gloeckler. November 10, 1993.

This memorandum includes a description of "C" list priorities which represent areas, projects, programs and activities that VESID would either postpone or eliminate. The purpose for doing this was to "clear the plates for the expanding A and B priorities having to do with Phase II, III, mandated State and Federal requirements and key State agreements, directions and interagency goals, etc."

25) Blueprint for Implementation of the Recommendations of the Regents Select Commission on Disability.

As the title suggests, this document contains the recommendations of the Regents Select Commission on Disability which focuses on issues affecting New York State's system of serving individuals with disabilities. The recommendations that appear in this document are to increase the placement of students in the least restrictive environments; critically review the Committee on Special Education process through which students access the educational services they need; Establish and enforce performance standards based on individual outcomes; design a multiyear planning process supported by a database that will provide accurate, comprehensive information about persons with disabilities; and allow the appropriate access to and transfer of assistive technology among programs based on the needs of the individual.

26) "Memorandum - Managing VESID's Resources." From Lawrence C. Gloeckler, To all VESID Managers. March 19, 1993.

Unprecedented growth in case service costs, increases in the fringe benefit and indirect rates, and less than anticipated growth in federal funding created the need for VESID to contain and control payroll and other costs. This memorandum describes the principles and priorities which govern the management of VESID's staff resources in light of these developments.

27) American Indian Rehabilitation Presentation: Outline.

VESID established a priority and commitment to assist the American Indian Nation governments of New York State to determine the nature and prevalence of individual disabilities within their populations; and identify what services would be necessary to address the needs of the Indian members within their jurisdiction. Through the activities of the Native American Research Project the Indian Nations expressed a clear desire to initiate their own rehabilitation services programs.

28) "Memorandum - Implementation of the Vocational Rehabilitation Act Amendments." From Michael Plotzker, To Several VESID employees.

Attached to this memorandum are the activities which were identified as needing to be undertaken in order to implement the Vocational Rehabilitation Act amendments. Included are the overall plan and specific documents relating to personnel preparation and technology.

29) No Title. Running Head reads "Attachment to SID (D) 4."

This report highlights two initiatives that specifically address issues of unserved and underserved individuals with disabilities. These are the Native American Independent Living Services Research Project and the Harlem Independent Living Center. The final section of this report highlights major goals and objectives that VESID will address in coming years to improve and enhance quality independent living services for people with disabilities in New York State.

30) American Indian Coalition of Rehabilitation and Independent Living Service Programs of New York State.

This document outlines Phase II of the Native American Project. The thrust of Phase II is to design, plan and develop a comprehensive Indian program to deliver rehabilitation and independent living services to American Indian individuals with disabilities residing within or in proximity to a number of the Indian Nation communities. The development phase contemplates a three-stage process by which the Indian representatives will collectively formulate the basic Coalition structure and set forth guidelines for its operation; design and plan their individual program operations; and begin start up activities upon receiving notice of available funding resources.

31) Memoranda of Understanding.

This document is a list of titles and signature dates for several memoranda of understanding between various groups (i.e. VESID, EMS, SED, OMH, OMRDD, DOL and DED) that work with individuals with disabilities.

32) Item for Discussion: Linking Services for Individuals with Disabilities - Discussion on Activities for Implementation of Policies. From Lawrence C. Gloeckler, To The Honorable the Members of the Board of Regents Committee on Services for Individuals with Disabilities. October 25, 1990.

Early in 1990 the Board of Regents approved ten policies for Linking Services for individuals with Disabilities transitioning from secondary education programs to higher education, adult or continuing education or employment. The report attached to this letter provides recommendations for actions to be taken to implement the ten policies. The report includes steps to implement the policies, evaluation actions for each policy, and projected timelines.

33) Interim 1994 State Plan for the State Vocational Rehabilitation Services Program and the State Plan Supplement for the State Supported Employment Services Program. The State Education Department. The University of the State of New York.

In accordance with the Rehabilitation Act of 1973 as amended, VESID, as the designated rehabilitation agency, must submit an amendment to the State Plan each year. This document serves as the 1994 amendment to the state plan. The Interim 1994 State Plan for the State Vocational Rehabilitation Services Program and the State Plan Supplement for the State Supported Employment Services Program is divided into the following sections:

Section I: A Description of the Public Comment Process;

Section II: Required Attachments Under the Rehabilitation ACT Amendments of 1992; and

Section III: Preprint Required for the Interim 1994 State Plan.

34) Final Report 1992 Operational Plan. The Office of Vocational and Educational Services for Individuals with Disabilities.

This document is a series of tables that contain the six 1992 VESID priorities. Within each priority are listed goals, specific objectives, coordinating units, completion dates and expected outcomes. The six priorities are

Priority 1: Integrated Employment: VESID will increase the number of people in integrated employment placements.

Priority 2: Interagency Activities: VESID will ensure that services provided by the Department for persons with disabilities, of any age, are coordinated with other New York State agencies and will be integrated, non-duplicative and comprehensive.

Priority 3: Intra-Agency Activities: VESID will work with all Offices of the Education Department to increase the utilization of programs and services, under the auspices of the State Education Department, for all persons with disabilities.

Priority 4: Improving Consumer Services: VESID will improve and expand consumer services leading to vocational outcomes designed to meet the needs of persons with disabilities in such a manner to encourage their full and independent participation in society. VESID will place a special emphasis on ensuring the quality of such services.

Priority 5: Fostering Independent Living: VESID will promote services and programs to enhance independent living for individuals with disabilities.

Priority 6: Management Development: VESID will improve program and fiscal management of Office procedures.